These Extraterritorial Riders are part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder.
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ET Riders .......................................................... Included in this document
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Arizona. The benefits below will apply instead of those in your booklet-certificate.

Notice
YOUR CERTIFICATE OF INSURANCE MAY NOT PROVIDE ALL BENEFITS AND PROTECTIONS PROVIDED BY LAW IN ARIZONA. PLEASE READ THE CERTIFICATE CAREFULLY.

When you are injured
If someone else caused you to need care – say, a careless driver who injured you in a crash – you may have a right to get money. We are not entitled to that money.

The difference between a complaint and an appeal
Complaint
You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal
The appeal process information packet explains all of your appeal rights. We sent you a copy of this. If you need another copy you can obtain one by calling us. When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.
Claim decisions and appeal procedures
Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of an adverse benefit determination
Urgent care or pre-service claim appeal
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal
You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. We will assign your appeal to someone who was not involved in making the original decision.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Exhaustion of appeal process
In most situations, you must complete the two levels of appeal with us before you can take these other actions:

• Contact the Arizona Department of Insurance to request an investigation of a complaint or appeal
• File a complaint or appeal with the Arizona Department of Insurance
• Appeal through an external review process
• Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

• You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
• We did not follow all of the claim determination and appeal requirements of Arizona or federal Department of Health and Human Services.
**External review**
External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

**IRO decisions**
The IRO will make a decision and notify the Insurance Director. The Insurance Director will notify us, you and your provider.

Sometimes you can get a faster external review decision. Your provider must call us or send us a request for external review form.

**Utilization review**
Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your provider or your network pharmacy. The outcome of the review may include:
- Limiting coverage of a drug to one prescribing provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

**Recordkeeping**
We will keep the records of all complaints and appeals for at least 10 years.

**Fees and expenses**
We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

![Signature]
Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Arizona Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in California. The benefits below will apply instead of those in your booklet-certificate.

Who can be on your plan (who can be your dependent)
You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your “dependents”.)

- Your legal spouse
- Your civil union partner
- Your domestic partner

Routine cancer screenings
Eligible health services include routine cancer screenings which also include:

- Cervical cancer screenings

Osteoporosis
Eligible health services include the diagnosis, treatment and management of osteoporosis by a physician. The services include Food and Drug Administration approved technologies, including bone mass measurements.

Anesthesia and hospital charges for dental care
Eligible health services include anesthesia for dental care only if you have a condition that requires that a dental procedure be done in a hospital or outpatient surgery center and you are:

- Under 7 years old
- Developmentally disabled (at any age)
- In poor health and have a medical need for general anesthesia (at any age)

Comprehensive infertility services
Eligible health services include comprehensive infertility care. The first step to using your comprehensive infertility health care services is enrolling with our National Infertility Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.
Infertility services

You are eligible for infertility services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse or domestic partner, referred to as “your partner”.
- There exists a condition that:
  - Is demonstrated to cause the disease of infertility.
  - Has been recognized by your physician or infertility specialist and documented in your or your partner’s medical records.
- You or your partner have not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner do not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

<table>
<thead>
<tr>
<th>You are</th>
<th>Number of months of unprotected timed sexual intercourse:</th>
<th>Number of donor artificial insemination cycles: Self paid/not paid for by plan</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
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</thead>
<tbody>
<tr>
<td>A female under 35 years of age with a male partner</td>
<td>A. 12 months or more or</td>
<td>B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test</td>
</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Does not apply</td>
<td>At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test</td>
</tr>
<tr>
<td>A female 35 years of age or older with a male partner</td>
<td>A. 6 months or more or</td>
<td>B. At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40</td>
</tr>
<tr>
<td>Scenarios</td>
<td>Requirements</td>
<td>Duration</td>
<td>Notes</td>
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<tr>
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</tr>
<tr>
<td>A male of any age with a female partner under 35 years of age</td>
<td>12 months or more</td>
<td>Does not apply</td>
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<tr>
<td>Does not apply</td>
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<tr>
<td>A male of any age with a female partner 35 years of age or older</td>
<td>6 months or more</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td></td>
</tr>
<tr>
<td>Does not apply</td>
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Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll in the infertility program.
- Assist you with precertification of eligible health services.
- Coordinate precertification for comprehensive infertility when these services are eligible health services.
- Evaluate your medical records to determine whether comprehensive infertility services are reasonably likely to result in success.
- Determine whether comprehensive infertility services are eligible health services.

Your provider will request approval from us in advance for your infertility services. We will cover charges made by an infertility specialist for the following infertility services:

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination.

A “cycle” is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.
**Advanced reproductive technology**

**Eligible health services** include Assisted Reproductive Technology (ART). ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

You are eligible for ART services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse or domestic partner, referred to as “your partner”. Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned treatment for medical conditions that will result in infertility.
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility**.
  - Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner’s medical records.
- You or your partner has not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have exhausted the comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

<table>
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<tr>
<th>You are</th>
<th>Number of months of unprotected timed sexual intercourse:</th>
<th>Number of donor artificial insemination cycles: Self paid/not paid for by plan</th>
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<tr>
<td>A female under 35 years of age with a male partner</td>
<td>A. 12 months or more</td>
<td>B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</td>
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<td>or</td>
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</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Does not apply</td>
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<tr>
<td><strong>A female 35 years of age or older with a male partner</strong></td>
<td><strong>A.</strong> 6 months or more <strong>or</strong></td>
<td><strong>B.</strong> At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40 to use your own eggs, embryos or donor eggs or embryos.</td>
</tr>
<tr>
<td><strong>A female 35 years of age or older without a male partner</strong></td>
<td>Does not apply</td>
<td>At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40 to use your own eggs, embryos or donor eggs or embryos.</td>
</tr>
<tr>
<td><strong>A male of any age with a female partner under 35 years of age</strong></td>
<td>12 months or more</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>
A male of any age with a female partner 35 years of age or older

6 months or more

Does not apply

Does not apply

Does not apply

- If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

**Fertility preservation**

Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when you:

- Are believed to be infertile
- Have planned services that will result in infertility such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapies
  - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning treatment that is demonstrated to result in infertility. Planned treatments include:
  - Bilateral orchiectomy (removal of both testicles)
  - Bilateral oophorectomy (removal of both ovaries)
  - Hysterectomy (removal of the uterus)
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility

The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

<table>
<thead>
<tr>
<th>You are</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
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<td>A female under 35 years of age</td>
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<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.</td>
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</table>

**Eligible health services** for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are infertile.

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll in the infertility program.
- Assist you with precertification of eligible health services.
- Coordinate precertification for ART services and fertility preservation services when these services are eligible health services. Your provider should obtain precertification for fertility preservation services.
through the NIU either directly or through a reproductive endocrinologist.

- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are eligible health services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your provider will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:

- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the What your plan doesn’t cover - some eligible health service exceptions section.)
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with obtaining sperm from your partner when they are covered under this plan for ART services.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.

A “cycle” is an attempt at a particular type of infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, “one” cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Eligible health services for ESET will be paid on the same basis as any other ART services benefit.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: California Medical ET
Issue Date: January 23, 2023
Additional Information Provided by Aetna Life Insurance Company

Inquiry Procedure
The plan of benefits described in the Booklet-Certificate is underwritten by:

Aetna Life Insurance Company (Aetna)
151 Farmington Avenue
Hartford, Connecticut 06156

Telephone: (860) 273-0123

If you have questions about benefits or coverage under this plan, call Member Services at the number shown on your Identification Card. You may also call Aetna at the number shown above.

If you have a problem that you have been unable to resolve to your satisfaction after contacting Aetna, you should contact the Consumer Service Division of the Department of Insurance at:

300 South Spring Street
Los Angeles, CA 90013
https://www.insurance.ca.gov/01-consumers/101-help/index.cfm

Telephone: 1-800-927-4357 or 213-897-8921

You should contact the Bureau only after contacting Aetna at the numbers or address shown above.

Participating Providers
We want you to know more about the relationship between Aetna Life Insurance Company and its affiliates (Aetna) and the participating, independent providers in our network. Participating physicians are independent doctors who practice at their own offices and are neither employees nor agents of Aetna. Similarly, participating hospitals are neither owned nor controlled by Aetna. Likewise, other participating health care providers are neither employees nor agents of Aetna.

Participating Providers are paid on a ‘Discounted Fee For Service’ arrangement. Discounted fee for service means that participating providers are paid a predetermined amount for each service they provide. Both the participating provider and Aetna agree on this amount each year. This amount may be different than the amount the participating provider usually receives from other payers.
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Colorado. The benefits below will apply instead of those in your booklet-certificate.

Cleft Palate and Cleft Lip Conditions

Eligible health services include services and supplies for the treatment of cleft palate and cleft lip conditions.

Services and supplies include:

- Oral and facial surgery, audiological and otolaryngology assessment and treatment
- Prosthetic treatment to include obturators, speech appliances, and feeding appliances
- Habilitative speech therapy
- Orthodontia at any age

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial for a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials and all of the following conditions are met:

- Your physician recommends participation in the clinical trial because it has the potential to provide a therapeutic health benefit to you
- Your care is provided by a certified, registered, or licensed provider working within the scope of their practice
- Your treatment is provided in a facility and by personnel who have the proper experience and training
- Prior to participation in a clinical trial or study, you sign a statement of consent indicating that you have been informed of the procedure, alternative methods of treatment, and the risks associated with participation in the clinical trial or study

Coverage is limited to benefits for routine patient services provided within the network if your plan does not provide coverage for out of network expenses.
The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

**Experimental or investigational therapies**

**Covered services** include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have a disabling, progressive or other life-threatening disease or condition, as defined and amended under the September 19, 2000 Medicare national coverage decision regarding clinical trials.

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

**Early intervention services**

These are services delivered by a qualified early intervention service **provider** as described under Part C of the Individuals with Disabilities Education Act. They are available for children from birth to age 3 who are eligible for these services. No deductible or copay applies unless this benefit is provided under a qualified High Deductible Plan.

**Covered services** include:

- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology

**Maternity and related newborn care**

**Covered services** include pregnancy (prenatal), **complications of pregnancy** care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

**Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries
Nutritional support
For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula, low protein modified food products and medical foods ordered by a physician for the treatment of phenylketonuria or an inherited disease of amino, organic and fatty acids as well as severe protein allergic conditions.

Except as covered above, the following are not covered services:
- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Other nutritional items

Vision care
If your plan provides coverage for a routine vision exam, you don’t have to access vision care through your PCP. You may go directly to a network ophthalmologist or optometrist for covered services.

Complications of pregnancy
Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from the pregnancy, but are adversely affected by the pregnancy or caused by the pregnancy, including, but not limited to:
- Acute nephritis
- Nephrosis
- Cardiac decompensation
- Missed abortion
- Non-elective cesarean section
- Termination of ectopic pregnancy
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible

Complications of pregnancy do not include conditions associated with the management of a difficult pregnancy such as:
- False labor
- Occasional spotting
- Morning sickness
- Physician prescribed rest during pregnancy
- Hyperemesis gravidarum
- Pre-eclampsia

A percentage paid by a covered person for a covered service.
**Telemedicine**

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Any other method required by law

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

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Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Colorado Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Connecticut. The benefits below will apply instead of those in your booklet-certificate.

Precertification
Failure to pre-certify your eligible health services when required will result in a benefit reduction. Covered benefits will never be reduced by more than 50% of the benefits that would have been payable or $500, whichever is less.

How COB works with Medicare
When you are covered under Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare. This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Connecticut Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Delaware. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Mental health treatment

Covered services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:

- Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group, and family therapies for the treatment of mental disorders
  - Other outpatient mental health treatment such as:
    o Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
    o Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      ▪ You are homebound
      ▪ Your physician orders them
      ▪ The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
      ▪ The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
Electro-convulsive therapy (ECT)
Transcranial magnetic stimulation (TMS)
Psychological testing
Neuropsychological testing
23 hour observation
Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

**Substance related disorders treatment**

Covered services include the treatment of substance related disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- Inpatient room and board, at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.

Treatment of substance related disorders in a general medical hospital is only covered if you are admitted to the hospital's separate substance related disorders section or unit, unless you are admitted for the treatment of medical complications of substance related disorders. As used here, “medical complications” include, but are not limited to:
  - Electrolyte imbalances
  - Malnutrition
  - Cirrhosis of the liver
  - Delirium tremens
  - Hepatitis

- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group, and family therapies for the treatment of substance related disorders
  - Other outpatient substance related disorders treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    - Ambulatory or outpatient detoxification which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - 23 hour observation
    - Peer counseling support by a peer support specialist
A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Delaware Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Florida. The benefits below will apply instead of those in your booklet-certificate.

THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Cleft lip and palate

Covered services include treatment for a congenital cleft lip or cleft palate. This includes:

- Orthodontics
- Oral surgery
- Otologic services
- Nutrition services
- Audiological and speech/language treatment involved in the management of birth defects known as cleft lip, cleft palate or both

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of jaw joint disorder by a provider, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not covered services:

- Non-surgical dental services, and therapeutic services related to jaw joint disorder
The following has been added to or replaced in the Eligibility, starting and stopping coverage Who can be a dependent on this plan section of your booklet-certificate.

- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    - Under 26 years of age
      - A dependent child who is under 26 years of age will be covered until the end of the calendar year after they have reached age 26
      - A dependent child from the end of the calendar year in which the child turns age 26 until the end of the calendar year in which the child turns age 30, provided the child is:
        - Unmarried
        - A resident of Florida or a full-time or part-time student
        - Not eligible for Medicare and not covered under another group or individual health benefit plan

The following has been added to or replaced in the We end your coverage section of your booklet-certificate.

**Why would we end your coverage?**

Your coverage may end if you act in a way that prevents you from having a good relationship with a network provider. We may also end your coverage if you act in a way that affects our business operations. We will give you 45 days notice in writing if we end your coverage for any of these reasons.

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Florida Medical ET
Issue Date: January 23, 2023
The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Georgia. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Ambulance/Emergency Services
If your plan includes coverage for expenses related to non-emergency use of the emergency room, those expenses will also apply towards your plan’s maximum out of pocket limit. If your plan includes coverage for out-of-network expenses, non-emergency ambulance services received from an out-of-network provider or other health care provider are paid the same as in-network. If your plan includes coverage for out-of-network expenses and provides coverage related to non-emergency care in a hospital emergency room, those expenses received from an out-of-network provider or other health care provider are paid the same as in-network.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Dental care anesthesia
Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist’s office due either to age or medical condition.

The following are not covered services:
- The related dental service unless specifically listed as a covered service in this certificate

Jaw joint disorder treatment
Covered services include the diagnosis, surgical and non-surgical treatment of jaw joint disorder by a provider, including:
- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)
This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Georgia Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Illinois. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Abortion

Covered services include services and supplies provided by a physician for an abortion

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Immunizations

Covered services include preventive immunizations for infectious diseases.

Doses, recommended ages and recommended population vary.

- Adults:
  - Herpes Zoster
  - Mumps
  - Rubella

- Adults and children from birth to age 18
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus (HPV)
  - Influenza (flu shot)
  - Measles
  - Meningococcal
  - Pertussis (whooping cough)
  - Pneumococcal
  - Tetanus
  - Varicella (chickenpox)
  - Shingles if you are 60 years of age or over
• Children from birth to age 18:
  o Haemophilus influenza type b
  o Inactive poliovirus
  o Rotavirus

The following are not preventive covered services:
• Immunizations that are not considered preventive care, such as those required due to your employment or travel

Routine cancer screenings
Covered services include the following routine cancer screenings:
• Low dose mammography screening, for women age 35 and older, (including x-ray examination, digital mammography and breast tomosynthesis) for the presence of occult breast cancer as follows:
  – For women 35-39, a baseline mammogram
  – For women 40 years of age and older, annually
  – For women under 40, with a family or prior personal history of breast cancer, positive genetic testing, or other risk factors, at necessary age and intervals
  – Comprehensive ultrasound screening and MRI of the entire breast(s) when a mammogram demonstrates heterogenous or dense breast tissue, as determined by your physician
  – Screening MRI, as determined by your physician
• Annual digital rectal exams and prostate specific antigen (PSA) tests as recommended by your, Physician. This includes:
  – Asymptomatic men age 50 and older
  – African-American men age 40 and over
  – Men age 40 and over with family history of prostate cancer
  – Colorectal cancer screening for adults over 50
• Colonoscopies including pre-procedure specialist consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
• Double contrast barium enemas (DCBE)
• Fecal occult blood tests (FOBT)
• Lung cancer screenings: adults age 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years
• Sigmoidoscopies

Well woman preventive visits
A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:
• Office visit to a physician, PCP, OB, GYN or OB/GYN for services including annual Pap smears including surveillance tests for ovarian cancer for women at risk for ovarian cancer.
• Preventive care breast cancer (BRCA) gene blood testing
• Clinical breast exams as follows:
  – For women over 20 years of age but less than 40, at least every 3 years
  – For women 40 years of age and older, annually
• Breast cancer chemoprevention counseling
• Cervical cancer screening for sexually active women
• Chlamydia infection screening for younger women and other women at higher risk
• HIV screening and counseling for sexually active women
• Osteoporosis screening for women over age 60 depending on risk factors
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

**Covered services** for pregnant women or women who may become pregnant include:
- Anemia screening on a routine basis
- Folic acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis screening
- Urinary tract or other infection screening

**Reconstructive breast surgery and supplies**

**Covered services** include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema or implant removal
  - Prostheses
  - A physician office visit or in-home nurse visit within 48 hours after discharge

**Reconstructive surgery and supplies**

**Covered services** include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your surgery is to implant or attach a covered prosthetic device.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the surgery is to improve function
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

**Covered services** also include the procedures or surgery to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:
- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The surgery or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:
- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

The following has been added to or replaced in the *How your plan works, Precertification* section of your booklet-certificate.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:
For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary.

**Step therapy** is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact us or go online to get the most up-to-date precertification requirements and list of step therapy drugs.

**Important note:**
Precertification and step therapy requirements do not apply to FDA-approved prescription drugs used for the treatment of substance related disorders, other than those established by applicable criteria.

**Requesting a medical exception**
Sometimes you or your provider may ask for a medical exception to request coverage for a prescription drug that is:

- Not covered
- Discontinued (for reasons other than safety or drug manufacturer withdrawal)
- Ineffective in the treatment of your disease or medical condition
- Likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance based on:
  - Your known relevant physical and mental characteristics
  - The known characteristics of the drug regimen from a step therapy requirement or dosage limitation

You, someone who represents you or your provider can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours of receipt. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members. If the medical exception request is approved by us, you will receive coverage for the prescription drug according to the terms of your group policy.

You, someone who represents you or your provider may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your provider of our decision. In the case of denial, we will provide you with:

- The reason for the denial
- An alternate covered medication (if applicable)
- Information for submitting an appeal of the denial.

The following has been added to or replaced in the *How your plan works* section of your booklet-certificate.
Benefit payments and claims
If benefits are not paid within 30 days after proof of loss is received, the network provider is entitled to 9% interest. Interest will be calculated from the 30th day until the date the benefits are paid. However, interest less than $1 may not be paid.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Illinois Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Massachusetts. The benefits below will apply instead of those in your booklet-certificate.

Interpreter and translation services

TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

如欲使用免費語言服務，請致電 1-888-982-3862. (Chinese)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

(Arabic) للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 382-988-1-1.
Physician profiling
Physician profiling information is available from the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Maximum coinsurance differential for network plans
In no event will the covered amount for In-Network charges exceed more than 20% of the covered amount for Out-of-Network charges.

Clinical trials
Routine patient costs
Covered services include routine patient costs or “patient care services” you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

“Patient care services” means a healthcare item or service that is given to you for being enrolled in a qualified clinical trial that:
- Is consistent with the usual and customary standard or care for someone with your diagnosis
- Is consistent with the study protocol for the clinical trial
- Would be covered if you did not participate in the clinical trial

The following are not covered services:
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Covered equipment under the Diabetic services, supplies, equipment and self-care programs benefit also include foot orthotic devices including orthopedic shoes and inserts.
Early intervention services
These are services delivered by a qualified early intervention service provider as described under Part C of the Individuals with Disabilities Education Act. They are available for children from birth to age 3 who are eligible for these services.

Covered services include:
- Speech and language therapy
- Occupational therapy
- Physical therapy
- Assistive technology

Hearing aids
Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Covered services include prescribed hearing aids and the following hearing aid services:
- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist, otologist or a licensed hearing instrument specialist
  - An audiologist who:
    o Is legally qualified in audiology
    o Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    o Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:
- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Infertility services
Basic infertility
Covered services include seeing a provider:
- To diagnose and evaluate the underlying medical cause of infertility.
- To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men, varicocele surgery.
Comprehensive infertility services

Covered services include the following infertility services provided by an infertility specialist:
- Ovulation induction cycle(s) while on injectable medication to stimulate the ovaries
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination

You are eligible for these covered services if:
- You or your partner have been diagnosed with infertility
- You have met the requirement for the number of months trying to conceive through egg and sperm contact

Aetna’s National Infertility Unit

The first step to using your comprehensive infertility covered services is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits. They can also help your provider with precertification. You can call the NIU at 1-800-575-5999.

Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.

Advanced reproductive technology (ART)

Advanced reproductive technology (ART), also called “assisted reproductive technology”, is a more advanced type of infertility treatment. Covered services include the following services provided by an ART specialist:
- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Intracytoplasmic sperm injection (ICSI).
- Sperm, egg and/or inseminated egg procurement and processing, or banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor’s insurer, if any.
- Cryopreservation (freezing) of eggs
- Assisted hatching
- Storage for up to 5 years and thawing of eggs, embryos, sperm or reproductive tissue.
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

You are eligible for ART services if:
- You or your partner have been diagnosed with infertility
- You have exhausted comprehensive infertility services benefits or have a clinical need to move on to ART procedures
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
Aetna’s National Infertility Unit
The first step to using your ART covered services is enrolling with our National Infertility Unit (NIU). Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and can give you information about our infertility Institutes of Excellence™ facilities. They can also help your provider with precertification. You can call the NIU at 1-800-575-5999.

Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.

Fertility preservation
Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:
- You are believed to be fertile
- You have planned services that are proven to result in infertility such as:
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles

Premature ovarian insufficiency
If your infertility has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

The following are not covered services:
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- The donor’s care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier’s care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, covered services include:

- No less than 48 hours of inpatient care in a hospital after a vaginal delivery
- No less than 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care provider. Covered services also include services and supplies needed for circumcision by a provider.

The following are not covered services:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

The following are added to Key Terms within Coordination of benefits.

- MedPay means medical coverage that can be purchased in connection with a motor vehicle liability policy.
- PIP means the personal injury protection coverage included in a motor vehicle liability policy.

The following rule is added as the first rule to apply in Determining who pays within Coordination of benefits.

<table>
<thead>
<tr>
<th>COB rule</th>
<th>Primary Plan</th>
<th>Secondary plan</th>
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<tbody>
<tr>
<td>A motor vehicle policy and are injured as a result of an accident with a motor vehicle</td>
<td>PIP is the primary plan for the first $2,000 of expenses. After that, plans will coordinate benefits in accordance with these COB provisions.</td>
<td>The plan which is not a motor vehicle policy</td>
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How do you extend coverage if you leave your job

If your employment ends because you leave your job, you may continue benefits for you and your dependents for 31 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 31 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any premium contribution needed

How do you extend coverage if your plant closes

If your employment ends due to a plant closing or partial closing, you may continue benefits (except dental coverage) for you and your dependents for 90 days. You must ask that your coverage continue within 31 days after it would cease due to a plant closing or partial closing.

Benefits will end before the end of the 90 days on the first of:

- The date you are eligible for benefits under another group plan
- The date you fail to make any contribution needed
How do you extend coverage for a former spouse
If you get divorced or separated from your spouse, your former spouse may continue to be covered unless a court judgment or divorce decree specifies otherwise, the same dependent premium and contribution rates will apply.

Benefits will end on the earliest of:
- The date specified in a judgment or decree
- The date your former spouse remarries
- The date you remarry
- The date you are no longer covered by the policy

In the event you remarry, your former spouse has the right, if so provided in the judgment, to continue to receive coverage under this agreement. If the judgment provides for this continuation of benefits, your former spouse may continue coverage under the group plan until the date specified in the judgment, the date your former spouse remarries or the date that you are no longer covered by the policy.

Notice of cancellation of coverage of your divorced or separated spouse will be mailed to the divorced or separated spouse at their last known address together with notice of the right to reinstate coverage retroactively to the date of cancellation.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Massachusetts Medical ET
Issue Date: January 23, 2023
Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Maine. The benefits below will apply instead of those in your booklet-certificate.

Children’s early intervention services
Covered services include children’s early intervention services for dependents from birth to 36 months with an identified development disability or delay, as described in the Federal Individual with Education Act, Part C, United States Code, Section 1411, et seq. These services may be provided by:

- Licensed occupational therapists
- Physical therapists
- Speech-language pathologists, or
- Clinical social workers
- Other providers as designated within the Disabilities Act

Diabetic services, supplies, equipment, and self-care programs
Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care provider certified in diabetes self-care training, including training and education services provided through ambulatory diabetes facilities authorized by the State’s Diabetes Control Project within the Bureau of Health
**Elective Abortion**

Unless coverage is provided under a policy issued in the state of Missouri, or a religious affiliated employer has elected not to provide, covered services also include the services and supplies provided for the voluntary termination of a pregnancy performed by a health professional.

**Hearing aids**

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

**Covered services** include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The maximum benefit payable is limited to $3,000 per hearing aid for each hearing-impaired ear every 36 months.

The following are not **covered services**:

- Replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within a 36 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

**Hospice care**

**Covered services** include inpatient and outpatient hospice care when given as part of a hospice care program.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
- Physical and occupational therapy
- Medical supplies
- Outpatient prescription drugs
- Psychological counseling
- Dietary counseling

The following are not **covered services**:
- Funeral arrangements
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

**Nutritional support**
For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

**Covered services** include parenteral and enteral formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

Covered services also include amino based elemental infant formula for any of the following documented conditions in children 2 and under:
- Symptomatic allergic colitis and proctitis
- Laboratory or biopsy proven allergic or eosinophilic gastroenteritis
- History of anaphylaxis
- Gastresophageal reflux disease
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a **provider**
- Cystic fibrosis
- Malabsorption of cow-milk based or soy-milk based infant formula

The submitted documentation for the above mentioned conditions must show:
- The formula is medically necessary as defined by Maine law
- The formula is 50% or more the primary nutrition source

Other commercial infant formulas, including cow and soy milks, have been tried, failed or are contraindicated.

The following are not **covered services**:
- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items
Routine Cancer Screenings
Mammograms under the Routine Cancer Screening benefit also include an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

Prosthetic device
A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Coverage includes:
- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Benefits equal to the limits provided by Medicare law

You may receive a prosthetic device as part of another covered service and therefore it will not be covered under this benefit.

The following are not covered services:
- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Telehealth
Covered services include telehealth consultations when provided by a physician, specialist, behavioral health provider or other telehealth provider acting within the scope of their license.

For those plans that use a network of providers, covered services for telehealth consultations are available from a number of different kinds of providers under your plan. Log in to your member website at https://www.aetna.com/ to review our telehealth provider listing and Contact us to get more information about your options, including specific cost sharing amounts

The following are not covered services:
- Telehealth kiosks

Protection from surprise bills
In cases where you try to stay in the network or unknowingly go out-of-network for your covered services, you may get a bill you didn’t expect. The plan may have approved coverage but you went outside the network without even knowing it.

When you’re a patient in a hospital, the hospital may be in the network but some services you receive can be from doctors and labs who are not in the network. You can tell the hospital staff to only use network services during your stay, but that’s not always possible. When you don’t know or have no choice, you will pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider, We will calculate any coinsurance amount based on the median network rate for that service. Contact us if you receive any surprise bills.
It is not a surprise bill when you knowingly choose to go outside the network. In this case, you will have to pay for it.

“Surprise bill” means a bill for health care services, including, but not limited to, emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. “Surprise bill” does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.

**Requesting a medical exception**

Sometimes you or your provider may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your provider can contact us. You will need to provide us with clinical documentation. We will process your request through our standard medical exception process within 72 hours or 2 business days, whichever is less, after receipt. If approved, you may receive the non-preferred drug benefit level and the exception will apply for the entire time you are taking the prescription. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

You, someone who represents you or your provider may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your provider of our decision.

**Continuity of prescription drugs**

If you are undergoing a course of treatment with a previously authorized prescription drug from another carrier and your coverage is replaced by this coverage, we will honor the prior carrier’s authorization. We will continue to provide coverage in the same manner until we review the authorization with your prescriber.

**Why would we end your coverage?**

We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.
Reinstatement due to cognitive impairment or functional incapacity
You may tell us if you would like a representative appointed or changed for notifications. If we discontinue coverage for failure to pay your premium, you or your representative, will receive the notification for termination 10 days before the termination date. You or your representative may submit a request for reinstatement within 90 days of the notice, showing that your failure to pay was due to native impairment or functional incapacity.

We may request medical documentation, at your expense, documenting the diminished capacity.

How you can extend coverage if your coverage ends because you are laid-off or you sustain an injury or disease compensable under Workers’ Compensation
If you are totally disabled when coverage ends, coverage for you and your dependents may be extended if your coverage ended because:

- You are temporarily laid-off
- You are permanently laid-off and are eligible for premium assistance pursuant to federal law; or
- You sustain an injury or disease that you claim to be compensable under Workers’ Compensation law.

You are eligible to extend your coverage under this provision if:

- You had group health coverage continuously under this plan for the last 6 consecutive months

Your dependents are eligible to extend coverage under this provision if:

- They had group coverage continuously under this plan for the last 3 consecutive months, unless they were not eligible for coverage until after the beginning of that 3 month period

You may extend coverage until the earliest of:

- When you become covered by another health benefits plan
- 12 months from the date of last employment
- The date the Workers’ Compensation Board determines that the injury or disease that entitles you to continue coverage under this provision is not compensable under applicable Workers’ Compensation law
- You fail to pay any required extension premium

We will extend your coverage only if you pay extension premiums. You must pay your first extension premium within 31 days after your coverage ends. Your extension premium may be up to 102% of the premium charged to a member who whose coverage has not ended.
Provider
A provider under your plan is defined as a **physician, health professional**, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don’t participate in Medicare.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

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Dan Finke  
President  
Aetna Life Insurance Company  
(A Stock Company)

Amendment: Maine Medical ET  
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder:  Pace University

Group policy number:  GP-0181579

Amendment effective date:  January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Michigan. The benefits below will apply instead of those in your booklet-certificate.

Elective Abortions
Elective abortions are only eligible for coverage if the procedure is necessary to preserve the life of the mother.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment:  Michigan Medical ET
Issue Date:  January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Minnesota. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

**Autism spectrum disorder**

Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Covered services include services and supplies provided by a physician or behavioral health provider for:
- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder
- Neurodevelopmental and behavioral health treatments and management

**Cleft lip and cleft palate**

Covered services include inpatient and outpatient medical and dental treatment for a covered dependent. This includes orthodontic treatment and oral surgery for the management of birth defects known as cleft lip and cleft palate.

For covered dependents age 19 up to the limiting age, covered services are limited to treatment that was scheduled or initiated prior to the dependent turning age 19.

Under this provision, if orthodontic treatment services are eligible for coverage under a dental insurance plan and this plan, the dental plan is primary and this plan is secondary.

**Clinical trials**

**Routine patient costs**

Covered services include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.
The following are not covered services:
- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Experimental or investigational therapies
Covered services include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial”

An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted for the prevention, detection or treatment of cancer or a life threatening condition that is not designed to exclusively test toxicity or disease pathophysiology and must be:
- Conducted under an investigational new drug (IND) application reviewed by the Unites States Food and Drug administration (FDA)
- Exempt from obtaining an investigational new drug application
- Approved or funded by:
  - The National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or a cooperating group or center for any of these entities
  - A cooperative group or center of the Unites States Department of Defense or the Unites States Department of Veteran Affairs
  - A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants
  - The Unites States Department of Veteran Affairs, Defense or Energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to:
    - Be comparable to the system of peer review of studies and investigations used by the NIH
    - Provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review

Dental care anesthesia
Covered services include anesthesia if you:
- Are a child under age 5
- Are severely disabled
- Have a medical condition and requires hospitalization or general anesthesia for dental care treatment

The following are not covered services:
- The related dental service unless specifically listed as a covered service under this certificate.

Diabetic services, supplies, equipment, and self-care programs
Covered services include:
- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
- Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care provider certified in diabetes self-care training, including medical nutrition therapy

**Durable medical equipment (DME)**

**Covered services** are DME and the accessories needed to operate it when:
- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But, there are some DME items Medicare covers that your plan does not.

**Covered services** include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

**Covered services** also include:
- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:
- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

**Hearing aids for a covered person age 18 and under**

Hearing aid means:
- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

**Covered services** include prescribed hearing aids and the following hearing aid services:
- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist
An audiologist who:
- Is legally qualified in audiology
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:
- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Home health care
Covered services include home health care provided by a home health care agency in the home, but only when all of the following criteria are met:
- You are homebound
- Your physician orders them
- The services take the place of a stay in a hospital or a skilled nursing facility, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a physician or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are ventilator dependent, covered services also include 120 hours of services by a home care nurse or personal care assistant during the time you are in a hospital, to serve as your communicator or interpreter with hospital staff.

If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See Rehabilitation services and Habilitation therapy services in this section and the schedule of benefits.

The following are not covered services:
- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

**Hospital care**

**Covered services** include inpatient and outpatient hospital care. This includes:
- Semi-private room and board (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a hospital, including the facility charge
- Services of physicians employed by the hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product

The following are not covered services:
- All services and supplies provided in:
  - Rest homes
  - Any place considered a person’s main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

**Jaw joint disorder treatment**

**Covered services** include the diagnosis, surgical and non-surgical treatment of jaw joint disorder by a provider, including:
- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome or a craniomandibular disorder
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

**Lyme disease treatment**

**Covered services** include treatment of diagnosed Lyme disease.

**Nutritional support**

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

**Covered services** include formula and low protein modified food products ordered by a physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids.

The following are not covered services:
- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items.
Pediatric streptococcal conditions
Covered services include services related to the treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute onset neuropsychiatric syndrome (PANS) including:
- Behavioral therapies to manage neuropsychiatric symptoms
- Plasma exchange
- Immunoglobulin
- Antibiotics and medications

Medications are considered covered services under the Prescription drugs-outpatient provision.

Port wine stain elimination
Covered services include services for elimination or maximum feasible treatment of port wine stains.

Anti-cancer drugs taken by mouth, including chemotherapy drugs
Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment.

For prescription drugs covered under this provision, for which certification was received, we will not impose a higher deductible, copayment or coinsurance not applied to prescription drugs that are used to kill or slow the growth of cancerous cells.

Anti-psychotic prescription drugs
Regardless of whether the drug is in the preferred drug guide, covered services include antipsychotic prescription drugs prescribed to treat an emotional disturbance or mental disordered if the prescriber:
- Indicates to the pharmacy, verbally or in writing, that the prescription must be dispensed as communicated
- Certifies in writing to us that the prescribing provider considered all equivalent drugs in the preferred drug guide and determined that the drug prescribed will best treat your condition

We will not provide coverage for a drug if the drug was removed for the preferred drug guide for safety reasons.

For prescription drugs covered under this provision, for which certification was received, we will not:
- Impose a special deductible, copayment or coinsurance not applied to prescription drugs that are in the preferred drug guide
- Require written certification each time the prescription is refilled or renewed

In addition, if the prescription drug used to treat the mental disorder or emotional disturbance has shown to effectively treat your condition, you may continue to receive the prescription drug for up to 1 year without the imposition of special payment requirements when:
- The preferred drug guide changes
- You change health plans
In order to be eligible for continuity of care:

- You must have been treated with the **prescription drug** for 90 days prior to the change
- Your prescriber must:
  - Indicate to the pharmacy, verbally or in writing that the **prescription** must be dispensed as communicated
  - Certify in writing to us that the **prescription drug** will best treat your condition

The continuing care benefit will be extended annually when:

- The prescriber re-indicates dispensed as communicated
- Renews the certification with us

We will grant a medical exception to the **preferred drug guide** when the prescriber indicates that the:

- **Preferred drug guide prescription drug**
  - Caused an adverse reaction
  - Is contradicted for you
- **Prescription drug** must be Dispensed as Written (DAW) to provide maximum medical benefits to you

**Prosthetic devices**

A prosthetic device is

- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects
- A scalp hair prosthesis worn for hair loss as a result of alopecia areata.

**Covered services** include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:  
- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

**Routine cancer screenings**

**Covered services** include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms - includes digital breast tomosynthesis for a person at risk for breast cancer
- Prostate specific antigen (PSA) tests
• Sigmoidoscopies
• Surveillance tests for ovarian cancer for women at risk for ovarian cancer - includes
  o CA-125 serum tumor marker testing
  o transvaginal ultrasound
  o pelvic examination
  o other proven ovarian cancer screening tests currently being evaluated by the Food and Drug Administration or the National Cancer Institute

*Screenings for men age 40 or over who are symptomatic or in a high-risk category and for all men age 50 or older.

Reconstructive surgery and supplies

Covered services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

• Your surgery is needed to correct an injury incidental to or following surgery resulting from injury of the involved body part
• Your surgery is to implant or attach a covered prosthetic device.
• Your surgery corrects a anatomical defect present at birth. The surgery will be covered if:
  − The defect results in facial disfigurement or functional impairment of a body part
  − The purpose of the surgery is to improve function
• Your surgery is needed because treatment of your illness resulted in facial disfigurement or functional impairment of a body part, and your surgery will improve function.
• Your covered dependent child’s surgery is needed due to a congenital disease or anomaly which resulted in functional defect, as determined by their provider.

Covered services also include the procedures or surgery to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

• The teeth were stable, functional and free from decay or disease at the time of the injury.
• The surgery or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

• The first placement of a permanent crown or cap to repair a broken tooth
• The first placement of dentures or bridgework to replace lost teeth
• Orthodontic therapy to pre-position teeth

The following has been added to or replaced in the How your plan works section of your booklet-certificate.

Surprise Bill

There may be times when you unknowingly receive services or do not consent to receive services from an out-of-network provider, even where you try to stay in the network for your covered services. You may then get a bill at the out-of-network rate that you didn’t expect. This is called a surprise bill.

An out-of-network provider cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as deductibles, copayments and coinsurance for the following services:

• Emergency services provided by an out-of-network provider, including independent freestanding emergency departments. Your final diagnosis will not determine whether services are emergency services.
  − Your coverage for emergency services will continue until you are evaluated and your condition is stabilized and:
Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care.

- Non-emergency surgical or ancillary services provided by an out-of-network provider at an in-network facility, except when the non-participating provider has satisfied the notice and consent criteria for out-of-network cost shares by:
  - Providing out-of-network notice to you of the estimated charges for the items and services and that the provider is a non-participating provider.
  - Obtaining consent from you to be treated and balance billed by the non-participating provider.
  - Providing written notice and obtaining consent within 72 hours of the item or service being delivered or, if the item or service is scheduled within that timeframe, at the time the appointment is made.

Surgical or ancillary services mean any professional services including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

A facility in this instance means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing facilities; residential treatment facilities; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

Any cost-sharing requirement for the items and services will be calculated based on the recognized amount which for surprise bill protection is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.

It is not a surprise bill when you knowingly choose to go outside the network and have signed a consent for these services. In this case, you will have to pay it.

Contact us if you receive any surprise bills or have any questions regarding what constitutes a surprise bill.

**Benefit payments and claims**

A claim is a request for payment that you or your health care provider submits to us when you want or get covered services. There are different types of claims. You or your provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within How your plan works. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

**Claim type and timeframes**

**Urgent care claim**
An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

**Pre-service claim**
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we *pre-certify* them. We will make a decision within 5 days.

**Post-service claim**
A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

**Concurrent care claim extension**
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a *hospital stay* or adding a number of visits to a *provider*. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

**Concurrent care claim reduction or termination**
A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as *copayments*, *coinsurance* and *deductibles* that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

**Filing a claim**
When you see a *network provider*, that office will usually send us a detailed bill for your services. If you see an *out-of-network provider*, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your *provider* must send us the bill within 12 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form that you can either get online or contact us to provide. You should always keep your own record of the date, *providers* and cost of your services.

The benefit payment determination is made based on many things, such as your *deductible* or *coinsurance*, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your *provider* for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Recission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.
We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the Complaints, claim decisions and appeal procedures section for that information.

The following has been added to or replaced in the Eligibility, starting and stopping coverage section of your booklet-certificate.

**Who can be a dependent on this plan**
You can enroll the following family members:
- Your legal spouse
- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren

The following has been added to or replaced in the Eligibility, starting and stopping coverage section of your booklet-certificate.

**How you can extend coverage if you are totally disabled when coverage ends**
Your coverage may be extended if you are totally disabled when coverage ends. You are “totally disabled” if you cannot work at your occupation within the first 2 years of your disability or you cannot work at your own occupation or any other occupation for pay or profit after 2 years of disability.

Your covered dependent is “totally disabled” if that person is incapable of self-sustaining employment due to developments disability, mental or physical disability and depends mainly on you for support and maintenance.

You may extend coverage until the earliest of:
- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan

**How your dependent can extend coverage after you die**
Your dependents can continue coverage after your death if:
- You were covered at the time of your death
- The request is made within 31 days after your death, and
- Payment is made for coverage

Your dependent’s coverage will end on the earliest date:
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan

**Premium** for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents who are not survivors or a deceased insured.
How you can extend coverage after you are voluntarily or involuntarily terminated or laid off from employment

You and your dependents can continue coverage after you are voluntarily or involuntarily terminated or laid off from employment, except for gross misconduct, if:
- The request is made within 60 days after you are voluntarily or involuntarily terminated or laid off from employment
- Payment is made for the coverage

You and your dependents' coverage will end on the earliest date:
- The end of the 18 month period after the date after you are voluntarily or involuntarily terminated or laid off from employment
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- You or your dependent becomes covered by another health benefits plan
- Any required contributions stop

How you can extend coverage for a dependent after divorce and are no longer responsible for dependent coverage

Your dependent can continue coverage after you divorce if payment is made for the coverage. Your former spouse must have been covered under this group policy on the day before the entry of a valid decree of dissolution of marriage.

Your dependent’s coverage will end on the earliest date:
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- You or your dependent becomes covered by another health benefits plan
- Any required contributions stop

Premium for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents

How you can extend coverage for a dependent child that no longer qualifies as a dependent under the plan

Your dependent child can continue coverage when they no longer qualify as a dependent under the plan if payment is made for the coverage.

Your dependent child’s coverage will end on the earliest date:
- The end of the 36 month period after the date they no longer qualify as a dependent under the plan
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- Any required contributions stop

How you can extend coverage for a dependent after you enroll in Medicare

Your dependents can continue coverage after you enroll in Medicare if payment is made for the coverage.

Your dependent’s coverage will end on the earliest date:
- The end of the 36 month period after the date you enroll in Medicare
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
• Any required contributions stop

**Premium** for this extended coverage will not exceed 102% of the cost of the plan for other similarly situated dependents.

The following has been added to or replaced in the General provisions – other things you should know section of your booklet-certificate.

**When you are injured**
The following will only apply after you received a full recovery from another source. Full recovery does not include payments made by a health plan to or for your benefit.

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money from a third party. If you receive a full recovery from another source, we may be entitled to be reimbursed from that source for amounts we have paid for your care. We have that right of reimbursement no matter what source the money comes from – for example, the other driver, the policyholder, or another insurance company. Our right to be reimbursed will be offset by monies paid to account for the pro rata share of your costs, expenses, and reasonable attorney’s fees you spend to obtain your recovery from another source.

To help us get paid back, you are doing these things now:

- Agreeing to repay us from money you receive from a third party as a result of your injury, subject to the above offsets.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you’ll tell us within 30 days of when you seek money for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

The following has been added to or replaced in the Glossary section of your booklet-certificate.

**At risk for breast cancer**
At risk for breast cancer is any of the following:

- Having a family history with one or more first or second degree relatives with breast cancer
- Testing positive for BRCA1 or BRCA2 mutations
- Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology
- Having a previous diagnosis of breast cancer.

**At risk for ovarian cancer**
At risk for ovarian cancer is any of the following:

- Having a family history:
  - With one or more first or second degree relatives with ovarian cancer
  - Of clusters of women relatives with breast cancer
  - Of nonpolyposis colorectal cancer
- Testing positive for BRCA1 or BRCA2 mutations
Child health supervision
Appropriate services for a child from birth to age 6, including:

- Pediatric preventive services
- Immunizations
- Developmental assessments
- Laboratory services

Child health supervision age ranges and frequency are:

- Birth to 12 months, at least 5 visits
- 12-24 months, 3 visits
- 24-72 months, 1 per year

Child health supervision also includes immunizations as appropriate for a child from age 6 to 18, as defined by the Standards of Child Health Care issued by the American Academy of Pediatrics.

Jaw joint disorder
This is:

- A temporomandibular joint (TMJ) dysfunction, craniomandibular disorder or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Medically necessary, medical necessity
Health care services that we determine a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing restoring, maintaining, or treating an illness, deterioration, injury, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease

Generally accepted standards of medical practice mean:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Telehealth
A consultation between you and a physician, specialist, or behavioral health provider, or telehealth provider who is performing a clinical medical or behavioral health service by means of electronic communication.

The following has been added to or replaced in your booklet-certificate.

In no event will the covered amount for Out-Of-Network charges be less than 50% of the covered amount for In-Network charges.
This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Minnesota Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Mississippi. The benefits below will apply instead of those in your booklet-certificate.

Retail Pharmacy
A retail pharmacy may be used for up to a 90 day supply of prescription drugs.

Timely payment of claims
1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any other of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of services; if the provider
does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation an information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation an information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For the purposes of this provision, the term “pay” means that the insurer shall either send cash or a cash equivalent by the United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or if not so posted, or not send by United States mail, on the date of delivery of payment to the provider or the insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or to the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event the insurer fails to pay benefit when due, the person entitled to such benefits may bring action to recover such benefits, any interests which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Payment of claims
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed in this policy and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured’s death may, at the option of the insurer, be paid either to such
beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint
You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal
When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures
Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision.

Appeal of an adverse benefit determination
Urgent care or pre-service claim appeal
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.
Any other claim appeal
You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The policyholder’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

External review
External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not medically necessary, not appropriate, or we decided the service or supply is experimental or investigational

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To the U.S. Office of Personnel Management
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request
You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

The ERO will:
- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

**How long will it take to get an ERO decision?**
We will give you the ERO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a request for external review form.

There are two scenarios when you may be able to get a faster external review:

**For initial adverse benefit determinations**
- Your **provider** tells us a delay in receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
  - Be much less effective if not started right away (in the case of experimental or investigational treatment)

**For final adverse determinations**
- Your **provider** tells us a delay in receiving health care services would:
  - Be much less effective if not started right away (in the case of experimental or investigational treatment), or
  - The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

**Utilization review**
**Prescription** drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:
- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

**Recordkeeping**
We will keep the records of all complaints and appeals for at least 10 years.
**Fees and expenses**

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

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Dan Finke  
President  
Aetna Life Insurance Company  
(A Stock Company)

Amendment:  Mississippi Medical ET  
Issue Date:  January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Pennsylvania. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Coverage and exclusions section of your booklet-certificate.

Nutritional support
For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula and low protein modified food products ordered by a physician for the treatment of phenylketonuria or an inherited disease of amino and organic acids. No deductible applies unless this benefit is provided under a qualified High Deductible Plan.

The following are not covered services:
- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items

The following has been added to or replaced in the Coverage and exclusions, Prescription drugs – outpatient section of your booklet-certificate.
When prescription drugs are obtained at a retail pharmacy there will be no difference in copayments, deductibles, or maximum day supply than if you obtained the same prescription drugs using mail order pharmacy.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Pennsylvania Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

**Important note:** The following apply only if you live in Tennessee. The benefits below will apply instead of those in your booklet-certificate.

### Clinical trials

**Routine patient costs**

**Covered services** include routine patient costs you have from a provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Participation in a clinical trial will not be the sole reason to deny coverage.
Recovery of overpayments
We sometimes pay too much for covered services or pay for something that this plan doesn’t cover. If we do, we can require the person we paid, you or your provider, to return what we paid. If we don’t do that, we have the right to reduce any future benefit payments by the amount we paid by mistake up to 18 months after the overpayment was received, except in cases of fraud.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Tennessee Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Texas. The benefits below will apply instead of those in your booklet-certificate.

The following has been added to or replaced in the Preface section of your booklet-certificate.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Aetna, Inc.

To get information or file a complaint with your insurance company or HMO:

Call: Aetna's toll-free telephone number at 1-888-416-2277
Toll-free: 1-888-416-2277
Online: www.aetna.com
Email: aetnamemberservices@aetna.com
Mail: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091
¿Tiene una queja o necesita ayuda?
Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Aetna, Inc.
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
  Llame a: al numero de teléfono gratis de Aetna al 1-888-416-2277
  Teléfono gratuito: 1-888-416-2277
  En línea: www.aetna.com
  Correo electrónico: aetnamemberservices@aetna.com
  Dirección postal: Aetna, Inc., P.O. Box 14464, Lexington, KY 40512

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
  Llame con sus preguntas al: 1-800-252-3439
  Presente una queja en: www.tdi.texas.gov
  Correo electrónico: ConsumerProtection@tdi.texas.gov
  Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091
Exclusive Provider Disclosure Notice

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

- You have the right to an adequate network of preferred providers (known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

- You may obtain a current directory of preferred providers at the following website: www.aetna.com or by calling Aetna Member Services at the toll-free number on your ID card for assistance in finding available preferred providers. If the you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
The insurance policy under which this certificate is issued is not a policy of workers’ compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the workers’ compensation system.

Underwritten by Aetna Life Insurance Company
The following content is added or replaced in the *Coverage and Exclusions* section of your booklet-certificate:

**Autism spectrum disorder**

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger’s syndrome, or pervasive developmental disorder – not otherwise specified.

**Covered services** include the “generally recognized services provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

We will cover screenings of your dependent children for autism spectrum disorder. This is done at ages 18 months and 24 months.

Treatment for autism spectrum disorder is covered from the date of diagnosis.

We will cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan. You can receive treatment from a provider that meets at least one of the following criteria:

- Is licensed, certified or registered by an appropriate agency of Texas
- Has professional credentials that are recognized and accepted by an appropriate agency of the United States.
- Is certified as a provider under the TRICARE military health system.

You can also receive treatment from someone working under the supervision of a provider as described above. As used here, “generally recognized services” can include:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and behavior management
- Speech therapy
- Physical therapy
- Occupational therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

**Behavioral health**

**Mental health treatment**

**Covered services** include the treatment of mental health disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:

- Inpatient room and board at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, crisis stabilization unit, residential treatment center for children and adolescents, or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine or telehealth consultation)
  - Individual, group, and family therapies for the treatment of mental health disorders
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
o Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
o Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  ▪ Your physician orders them
  ▪ The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
  ▪ The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
o Electro-convulsive therapy (ECT)
o Transcranial magnetic stimulation (TMS)
o Psychological testing
o Neuropsychological testing
o Observation
o Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.

Substance related disorders treatment
Covered services include the treatment of substance related disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- Inpatient room and board, at the semi-private room rate (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychologist, social worker, or licensed professional counselor (includes telemedicine or telehealth consultation)
  - Individual, group, and family therapies for the treatment of substance related disorders
  - Other outpatient substance related disorders treatment such as:
    o Partial hospitalization treatment provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Intensive outpatient program provided in a facility or program for treatment of substance related disorders provided under the direction of a physician
    o Ambulatory or outpatient detoxification which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    o Observation
    o Peer counseling support by a peer support specialist

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Covered services will be covered under the same terms and conditions as medical and surgical benefits for any other physical illness.
Cardiovascular disease testing

Covered services include certain lab tests for the early detection of cardiovascular disease when a covered person has:

- Diabetes
- An intermediate or higher risk of getting coronary heart disease based on Framingham Heart Study prediction algorithms

The following lab tests may be done to screen for hardening and abnormal artery structure and function:

- Computed tomography (CT) scanning
- Ultrasonography

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a provider in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection, or treatment of cancer or other life-threatening disease or condition, as defined in the federal Public Health Service Act, Section 2709. An approved clinical trial must satisfy one of the following:

- Federally funded trials:
  - The study or investigation is approved or funded by one or more of the following:
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The Agency for Health Care Research and Quality
    - The Centers for Medicare & Medicaid Services
    - Cooperative group or center of any of the entities described above or the Department of Defense or the Department Veterans Affairs
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    - The Department of Veterans Affairs
    - The Department of Defense
    - The Department of Energy
    - The Food and Drug Administration
    - An institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application

Coverage is limited to benefits for routine patient services provided within the network.

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)
Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a provider under an “approved clinical trial” only when you have cancer or a terminal illness. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- Your provider determines, and we agree, that based on published, peer-reviewed scientific evidence you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by the institutional review board of a Texas institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Dental care services and anesthesia in a hospital or surgery center

Covered services include anesthesia and facility costs for dental care. Your provider must certify that the dental care cannot be performed in the dentist’s office due to a physical, mental, or medical condition.

The following are not covered services:

- The related dental services unless specifically listed as a covered service in this certificate.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Insulin and insulin analog preparation
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Injection devices including syringes, needles and pens
  - Injection aids, including devices used to assist with insulin injection and needleless systems
  - Diabetic test agents, including but not limited to, visual reading and test strips (blood glucose, ketone and urine)
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
  - Injectable glucagon’s
  - Glucagon emergency kit
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps and pump supplies
    - Repairs and necessary maintenance of insulin pumps if not covered by manufacturer’s warranty or purchase agreement
    - Rental fees for pumps during repair and maintenance
  - Blood glucose monitors without special features, unless required due to blindness
  - Podiatric appliances, including therapeutic shoes to prevent complications of diabetes
Prescribed self-care programs with a health care provider certified in diabetes self-care training

**Covered services** also include new or improved diabetic treatment, equipment and supplies that become available. They must be:
- Approved by the United States Food and Drug Administration
- **Prescribed** by your provider
- Sent to us in writing by your provider

All supplies, including medications and equipment for diabetes will be dispensed as written, and are not subject to preauthorization or step therapy requirements.

**Diagnostic follow-up care related to newborn hearing screening**
**Covered services** include necessary diagnostic follow-up care related to the newborn hearing screening test from birth through 24 months of age.

**Important Note:**
Once you have met your deductible, your cost share for diagnostic imaging using mammography, ultrasound imaging, or magnetic resonance imaging will be the same as mammograms performed for routine cancer screenings as described in the Preventive Care section when it is used to evaluate a breast abnormality detected by a physician or patient, or where there is a personal history of breast cancer or dense breast tissue.

This diagnostic imaging is not subject to any age limitations.

**Early intervention services for children with developmental delays**
**Covered services** for a child with developmental delays include:
- Occupational therapy evaluations and services
- Physical therapy evaluations and services
- Speech therapy evaluations and services
- Dietary or nutritional evaluations

The therapy should follow a specific treatment plan that:
- Details the treatment, and specifies frequency and duration
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate

If the child is homebound, therapy services may be provided in the child’s home.

**Emergency services**
When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

**Covered services** include only outpatient services to evaluate and stabilize an emergency medical condition in a hospital emergency room. You can get emergency services from network providers or out-of-network providers.

The types of services that are eligible for coverage include:
- A medical screening examination or other evaluation required by state or federal law and provided to covered enrollees in a hospital emergency facility, freestanding emergency care facility or comparable facility, necessary to determine if an emergency medical condition exists.
- Treatment to stabilize your condition.
• Care in an emergency facility, freestanding emergency care facility or comparable facility after you become stable. But only if the treating provider asks us, and we approve the service. We will approve or deny the request within an hour after receiving the request.

As always, you can get emergency services from network providers. However, you can also get emergency services from out-of-network providers. When you are treated by an out-of-network provider when a network provider is not reasonably available or for an emergency medical condition, we will reimburse the out-of-network provider at the usual and customary rate or at an agreed rate. Please contact us if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance, or copayments under your plan.

You will be credited for:
• Any amounts due to you that would have been paid if the provider were a network provider
• Any out-of-pocket amounts that you paid to the provider, in excess of the allowed amount. Such amounts will be credited to your Calendar Year deductible amount and plan coinsurance limits, as applicable

Out-of-network providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan based on the usual and customary rate or at an agreed rate. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and preauthorization requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-emergency services
If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits for this information.

Hearing aids, cochlear implants and related services
Covered services include hearing aids or cochlear implants and the following related services and supplies:
• Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
• Treatment related to hearing aids and cochlear implants, including:
  – Habilitation and rehabilitation necessary for educational gain
  – For cochlear implants, an external speech processor and controller
• Internal replacement of cochlear implants as medically necessary or audiologically necessary

Covered services include prescribed hearing aids and the following hearing aid services:
• Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  – A physician certified as an otolaryngologist or otologist
  – An audiologist who:
    o Is legally qualified in audiology
    o Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not covered services:
- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

**Home health care**

**Covered services** include home health care provided by a home health care agency in the home, but only when all of the following criteria are met:
- Your physician orders them
- The services take the place of a stay in a hospital or a skilled nursing facility
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a physician or social worker

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See Rehabilitation services and Habilitation therapy services in this section and the schedule of benefits.

The following are not covered services:
- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

**In vitro fertilization (IVF)**

**What are IVF services?**

IVF services are outpatient in vitro fertilization services performed to help a woman become pregnant.

**Covered services** include any IVF service that meets these three requirements:
- They are listed as covered in the Coverage and exclusions section
- They are not listed in as excluded in the Coverage and exclusions section
- They are not beyond any limits in the schedule of benefits

**In vitro fertilization**

You are eligible for IVF services if:
- The patient is covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse or domestic partner referred to as “your partner”. Dependent children are covered under this plan for IVF services only in the case of fertility preservation due to planned cancer treatment that will render the individual infertile
• The fertilization or attempted fertilization of the patient’s oocytes is made only with the sperm of the patient’s spouse
• The patient and the patient’s spouse have a history of infertility of at least five continuous years’ duration or the infertility is associated with:
  o Endometriosis
  o Exposure in utero to diethylstilbestrol (DES)
  o Blockage of or surgical removal of one or both fallopian tubes or
  o Oligospermia
• A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan
• The IVF procedures are performed at a medical facility that conforms to the minimal standards for programs of IVF adopted by the American Society for Reproductive Medicine

You can find a network IVF specialist and facility in several ways:
• Contact us
• From our National Infertility Unit (NIU): Our NIU can provide you with information about our Institutes of Excellence™ infertility facilities. You can reach our dedicated NIU at 1-800-575-5999.

Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help with enrollment, preauthorization and eligibility.

Your network provider will request approval from us in advance for your IVF services.

We will cover charges made by a network IVF specialist for outpatient in vitro fertilization services.

Maternity and related newborn care
Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services, including care and services for complications of pregnancy.

Complications of pregnancy are:
• Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:
  – Acute nephritis
  – Nephrosis
  – Cardiac decompensation
  – Missed abortion
  – Similar medical and surgical conditions of comparable severity
• The following conditions that occur during a period of gestation in which a viable birth is not possible:
  – Non-elective cesarean section
  – Termination of ectopic pregnancy
  – Spontaneous termination of pregnancy

Complications of pregnancy do not include:
• False labor
• Occasional spotting
• Physician prescribed rest during the period of pregnancy
• Morning sickness
• Hyperemesis gravidarum
• Pre-eclampsia
• Similar conditions associated with the management of a difficult pregnancy not constitution a
nosologically distinct complication of pregnancy.

Services and supplies for complications of pregnancy will be covered the same as any other illness or injury.

After your child is born, covered services include:
- No less than 48 hours of inpatient care in a health care facility after a vaginal delivery
- No less than 96 hours of inpatient care in a health care facility after a cesarean delivery
  A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for home visits after delivery by a health care provider.

These time frames apply if your child is born without any problem. If your provider tells us that you had a problem during your pregnancy or during childbirth, we will cover the stay the same as we would for any other illness or injury.

Covered services for newborn care include:
- Services and supplies needed for circumcision by a provider
- Treatment of congenital defects. These services will be covered the same as any other illness or injury

The following are not covered services:
- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support
For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Covered services include formula and low protein modified food products ordered by a physician for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino acid based elemental formula.

We will cover these items to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following are not covered services:
- Any food item, including:
  - Infant formulas
  - Nutritional supplements
  - Vitamins
  - Medical foods
  - Other nutritional items
Orthotic devices

Covered services include the initial orthotic device and subsequent replacement that your physician orders and administers.

We will cover the same type devices that are covered by Medicare. Your provider will tell us which device best fits your need. But we cover it only if we preauthorize the device.

Orthotic device means a customized medical device applied to a part of the body to:
- Correct a deformity
- Improve function
- Relieve symptoms of a disease

Coverage Includes:
- Repairing or replacing the original device. Examples of these are:
  - Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
  - Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device.

The following are not covered services:
- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Osteoporosis

Covered services include services to detect and prevent osteoporosis for:
- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with:
  - Vertebral abnormalities
  - Primary hyperparathyroidism
  - A history of bone fractures
- An individual who is:
  - Receiving long-term glucocorticoid therapy
  - Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Physician services

Covered services include services by your physician to treat an illness or injury. You can get services:
- At the physician's office
- In your home
- In a hospital
- From any other inpatient or outpatient facility
- By way of telemedicine or telehealth

Important note:
For behavioral health services, all in-person, covered services with a behavioral health provider are also covered services if you use telemedicine or telehealth instead.

Other services and supplies that your physician may provide:
- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care
The Types of services that require preauthorization section is revised as follows:

A **preauthorization** may not be required for some services if your **provider** meets the requirements of prior **preauthorization** approvals. Please contact your **physician** or us for additional information.

Your **provider** may request a renewal of an existing **preauthorization** within 60 days of the expiration date of the preauthorization. We will notify you of our decision before the expiration of the existing **preauthorization**.

**Partial fill dispensing for certain prescription drugs**

We allow a partial fill of your **prescription** if:

- Your **pharmacy** or **prescriber** tells us that:
  - The quantity requested is to synchronize the dates that the **pharmacy** fills your **prescription drugs**
  - The synchronization of the dates is in your best interest
- You agree to the synchronization

Your out-of-pocket expenses will be prorated based on the number of days’ supply.

**Prescription eye drops**

You may refill **prescription** eye drops to treat a chronic eye disease or condition if:

- The original **prescription** states that additional quantities are needed
- The refill does not exceed the total quantity of dosage units stated on the original **prescription**, including refills
- The refill dispensed on or before the last day of the prescribed dosage period and not earlier than the:
  - 21st day after the date a 30-day supply is dispensed
  - 42nd day after the date a 60-day supply is dispensed
  - 63rd day after the date a 90-day supply is dispensed

**Anti-cancer drugs taken by mouth, including chemotherapy drugs**

**Covered services** include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn’t approved by the FDA for this treatment.

Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the coinsurance or copayment applicable to a chemotherapy visit or cancer treatment visit. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. For more information see the *How your plan works – Medical necessity and preauthorization requirements* section.

**Nutritional supplements**

**Covered services** include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease or disorder of amino and organic acids. This includes coverage for amino-acid based elemental formula.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.
Covered services are covered to the same extent that the plan covers drugs that are available only on the orders of a physician.

The following has been added to or replaced in the Preventive care section of your certificate

Routine cancer screenings
Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure specialist consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, or a follow-up colonoscopy if the findings are abnormal
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
The following has been added to or replaced in the *Preventive care* section of your schedule of benefits

<table>
<thead>
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<th>Preventive care</th>
<th>Description</th>
<th>In-network</th>
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</tr>
<tr>
<td>Breast feeding</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>counseling and support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limit</td>
<td>6 visits in a group or individual setting</td>
<td>Visits that exceed the limit are covered under</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the <strong>physician</strong> services office visit</td>
</tr>
<tr>
<td>Breast pump,</td>
<td>Electric pump: 1 every 1 year</td>
<td></td>
</tr>
<tr>
<td>accessories and supplies</td>
<td>Manual pump: 1 per pregnancy</td>
<td></td>
</tr>
<tr>
<td>limit</td>
<td>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>purchase a new pump</td>
<td></td>
</tr>
<tr>
<td>Breast pump waiting</td>
<td>Electric pump: 1 year to replace an existing electric pump</td>
<td></td>
</tr>
<tr>
<td>period</td>
<td></td>
<td></td>
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<tr>
<td>Counseling for alcohol</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>or drug misuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for obesity,</td>
<td>5 visits/12 months</td>
<td></td>
</tr>
<tr>
<td>healthy diet</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Counseling for obesity,</td>
<td>Age 0-22: unlimited visits Age 22 and older: 26 visits per 12 months, of</td>
<td></td>
</tr>
<tr>
<td>healthy diet,</td>
<td>which up to 10 visits may be used for healthy diet counseling.</td>
<td></td>
</tr>
<tr>
<td>visit limit</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Counseling for sexually</td>
<td>2 visits/12 months</td>
<td></td>
</tr>
<tr>
<td>transmitted infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for tobacco</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>cessation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling for tobacco</td>
<td>8 visits/12 months</td>
<td></td>
</tr>
<tr>
<td>cessation visit limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning services</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>(contraception,</td>
<td>Contraceptive counseling limited to 2 visits/12 months in a group or</td>
<td></td>
</tr>
<tr>
<td>counseling)</td>
<td></td>
<td>individual setting</td>
</tr>
<tr>
<td>Family planning services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(contraception,</td>
<td></td>
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<tr>
<td>counseling) limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations limit</td>
<td>Subject to any age limits provided for in the comprehensive guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>supported by the Advisory Committee on Immunization Practices of the Centers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for Disease Control and Prevention</td>
<td></td>
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<tr>
<td></td>
<td>For details, contact your <strong>physician</strong></td>
<td></td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td>0% per visit, no <strong>deductible</strong> applies</td>
<td></td>
</tr>
<tr>
<td>Mammogram limits</td>
<td>One mammogram every year for covered persons age 35 and older.</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Limitation</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>When diagnostic imaging is used to evaluate a breast abnormality or where there</td>
<td>When diagnostic imaging is used to evaluate a breast abnormality or where there is a personal history of breast cancer or dense breast tissue it is not subject to any age or frequency limitations.</td>
<td></td>
</tr>
<tr>
<td>is a personal history of breast cancer or dense breast tissue it is not subject</td>
<td></td>
<td></td>
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<tr>
<td>to any age or frequency limitations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate specific antigen (PSA) test limits</td>
<td>One PSA test every year for covered persons age 45 and over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One PSA test every year for covered persons age 40 and older with a family history of prostate cancer, or other risk factor</td>
<td></td>
</tr>
<tr>
<td>Additional routine cancer screening limits</td>
<td>Subject to any age, family history and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF</td>
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</tr>
<tr>
<td></td>
<td>The comprehensive guidelines supported by the Health Resources and Services Administration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For more information contact your physician or see the Contact us section</td>
<td></td>
</tr>
<tr>
<td>Routine lung cancer screening</td>
<td>0% per visit, no deductible applies</td>
<td></td>
</tr>
<tr>
<td>Routine lung cancer screening limit</td>
<td>1 screenings every 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screenings that exceed this limit covered as outpatient diagnostic testing</td>
<td></td>
</tr>
<tr>
<td>Routine physical exam limits</td>
<td>0% per visit, no deductible applies</td>
<td></td>
</tr>
<tr>
<td>Routine physical exam limits</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months</td>
<td></td>
</tr>
<tr>
<td>Well woman GYN exam</td>
<td>0% per visit, no deductible applies</td>
<td></td>
</tr>
<tr>
<td>Pap smear or screening using liquid based cytology methods</td>
<td>One pap smear every 12 months for women age 18 or older</td>
<td></td>
</tr>
<tr>
<td>Gynecological exam that includes a rectovaginal pelvic exam</td>
<td>One exam every 12 months for women over age 25 who are at risk for ovarian cancer</td>
<td></td>
</tr>
<tr>
<td>Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and</td>
<td>One exam every 12 months for women age 18 and older</td>
<td></td>
</tr>
<tr>
<td>the CA 125 blood test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional well woman GYN exam limit</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
<td></td>
</tr>
<tr>
<td>Limit</td>
<td>1 visit</td>
<td></td>
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</tbody>
</table>
Prosthetic device
A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

We will cover the same type devices covered by Medicare. Your provider will tell us which device best fits your needs.

Coverage includes:
- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

You may receive a prosthetic device as part of another covered service and therefore it will not be covered under this benefit.

The following are not covered services:
- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies
Covered services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - Surgery on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses
- Unless you or your physician decide that a shorter time period for inpatient care is appropriate, covered services for reconstructive breast surgery include:
  - 96 hours of inpatient care following a mastectomy
  - 48 hours of inpatient care in a network health care facility after lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies
Covered services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your surgery is to implant or attach a covered prosthetic device.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the surgery is to improve function
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.
• Your surgery corrects a craniofacial abnormality. This includes an abnormal structure that is caused by developmental deformities, congenital defects, trauma, tumors, infections or disease. The surgery will be covered if:
  – The purpose of the surgery is to improve function or attempt to create a normal appearance.

Covered services also include the procedures or surgery to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:
• The teeth were stable, functional and free from decay or disease at the time of the injury.
• The surgery or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:
• The first placement of a permanent crown or cap to repair a broken tooth
• The first placement of dentures or bridgework to replace lost teeth
• Orthodontic therapy to pre-position teeth

Inpatient and outpatient treatment for acquired brain injury
Covered services include treatment for an acquired brain injury. An acquired brain injury does not include a congenital or degenerative illness or injury. It means a neurological injury to the brain, after birth, that results in loss of:
• Physical function
• Sensory processing
• Cognition
• Psychological behavior

The therapy is coordinated with us as part of a treatment plan intended to:
• Maintain or restore previous cognitive function
• Slow further loss of function

Covered services include the following therapies related to an acquired brain injury:
• Cognitive rehabilitation therapy
• Cognitive communication therapy
• Neurocognitive therapy and rehabilitation
• Neurobehavioral, neuropsychological, neuropsychological, and psychophysiological testing or treatment.
• Neurofeedback therapy
• Remediation
• Post-acute transition services
• Community reintegration services
• Post-acute care treatment due to, and related to, an acquired brain injury. If you have been unresponsive to treatment, this also includes checking from time to time to see if you become responsive.

Covered services also include care in an assisted living facility that is:
• Within scope of their license, and
• Within scope of the services provided under an accredited rehabilitation program for brain injury.

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the Short-term rehabilitation services section in the schedule of benefits.
The following are not covered services:
- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

The following content is added or replaced in the Coverage and Exclusions and Glossary section of your certificate:

**Telemedicine, teledentistry or telehealth**
Covered services include telemedicine, teledentistry or telehealth consultations when provided by a physician, specialist, behavioral health provider or other telemedicine or telehealth provider acting within the scope of their license.

Covered services for telemedicine, teledentistry or telehealth consultations are available from a number of different kinds of providers under your plan. Log in to your member website at https://www.aetna.com/ to review our telemedicine, teledentistry or telehealth provider listing and Contact us to get more information about your options, including specific cost sharing amounts.

The following are not covered services:
- Telephone calls
- Telemedicine or telehealth kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

**Teledentistry**
A health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist’s or health professional’s license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

**Therapies – chemotherapy**
**Chemotherapy**
Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

Covered services also include anti-cancer prescription drugs for chemotherapy. Coverage for oral anti-cancer prescription drugs will not be less favorable than for intravenously or injected anti-cancer medication covered as a medical benefit rather than as a prescription drug benefit. Also, the cost-sharing for anti-cancer prescription drugs will not exceed the coinsurance or copayment applicable to a chemotherapy visit or cancer treatment visit. Your prescriber or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the Preauthorization section for details.

The following content is added or replaced in the How your plan pays section of your booklet-certificate:

**Keeping a provider you go to now (continuity of care)**
You may have to find a new provider when:
- You join the plan and the provider you have now is not in the network
- You are already an Aetna member and your provider stops being in our network
However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

<table>
<thead>
<tr>
<th>If you are a new enrollee and your provider is out of network provider</th>
<th>When your provider stops participation with Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request for approval</strong></td>
<td>You need to complete a transition of coverage request form and send it to us. You can get this form by contacting us.</td>
</tr>
<tr>
<td><strong>Length of transitional period</strong></td>
<td>Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.</td>
</tr>
<tr>
<td><strong>How claim is paid</strong></td>
<td>Your claim will be paid at the network cost sharing level during the transitional period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a terminal illness and your provider stops participation with us</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request for approval</strong></td>
<td>Your provider should call us for approval to continue any care.</td>
</tr>
<tr>
<td><strong>Length of transitional period</strong></td>
<td>Care will continue during a transitional period for up to 90 days. This date is based on the date the provider terminated their participation with us.</td>
</tr>
<tr>
<td><strong>How claim is paid</strong></td>
<td>Your claim will be paid at not less than the network contract rate during the transitional period.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are pregnant and have entered your second trimester and your provider stops participation with Aetna</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request for approval</strong></td>
<td>Your provider should call us for approval to continue any care.</td>
</tr>
<tr>
<td><strong>Length of transitional period</strong></td>
<td>Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to delivery. This includes a post-delivery checkup within six weeks.</td>
</tr>
<tr>
<td><strong>How claim is paid</strong></td>
<td>Your claim will be paid at not less than the network contract rate during the transitional period.</td>
</tr>
</tbody>
</table>

If this situation applies to you, contact us for details. If we approve your request to keep going to your current provider, we will tell you how long you can continue to see the provider. If you are pregnant and have initiated a course of prenatal care, regardless of the trimester care was initiated, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the provider agrees to our usual terms and conditions for contracting providers.
NOTICE: “ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED.”

Coordination of benefits
The Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB). A plan is defined below under Key terms.

Order of benefit determination rules
When you are covered by two or more plans, the rules for determining the order of benefit payments are as follows:

- The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan.

- A plan does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except:
  - Coverage that you have because of membership in a group that is designed to supplement part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder.
  - Examples of these types of situations are:
    - Major medical coverages that are superimposed over base plan hospital and surgical benefits
    - Insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.

- A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.

- If the primary plan is closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an out-of-network provider or physician except for emergency services or authorized referrals that are paid or provided by the primary plan.

- When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contract is governed by the terms of the contracts. If more than one carrier pays or provided benefits under the plan, the carrier designated ad primary within the plan must be responsible for the plan’s compliance with these rules.

- If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plans’ benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of the secondary plan.

Key Terms
Here are some key terms we use in this section. These will help you understand this COB section.
**Plan:**
A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- A plan includes:
  - Group blanket or franchise accident and health insurance policies, excluding disability income protection coverage
  - Individual and group health maintenance organization evidences of coverage
  - Individual accident and health insurance policies
  - Individual and group preferred provider benefit plans and exclusive provider benefit plans
  - Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care
  - Medical care components of individual and group long-term care contracts
  - Limited benefit coverage that is not issued to supplement individual or group in-force policies
  - Uninsured arrangements of group or group-type coverage
  - The medical benefits coverage in automobile insurance contracts
  - Medicare or other governmental benefits as permitted by law

- A plan does not include:
  - Disability income protection coverage
  - The Texas Health Insurance Pool
  - Workers' compensation insurance coverage
  - **Hospital** confinement indemnity coverage or other fixed indemnity coverage
  - Specified disease coverage
  - Supplemental benefit coverage
  - Specified accident coverage
  - School accident-type coverages that cover students for accidents only, including athletic injuries, either on “24-hour” or a “to and from school” basis
  - Benefits provided in Long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and **custodial care** or for...
contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services

- Medicare supplement policies
- A state plan under Medicaid
- A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan
- Other nongovernmental plan
- An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible

Each plan for coverage is a separate plan, if a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan

**This plan:**
This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans

- **How this plan coordinates with like benefits:**
  Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

- **The order of benefit determination rules for this plan:**
  The order of benefit determination rules determines whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.
  - When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan’s benefits
  - When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense
Allowable expense:
Allowable expense is a health or dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person.

<table>
<thead>
<tr>
<th>• Allowable expense for benefits provided in the form of services:</th>
<th>When a plan provides benefits in the form of services the reasonable cash value of each service will be considered an allowable expense and a benefit paid.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expenses that are not allowable expenses:</td>
<td>An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.</td>
</tr>
</tbody>
</table>

Some expenses and services are not allowable expenses. Here are some examples:

• The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

• If a person is covered by two or more plans that don’t have a negotiated charge and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for specific benefit is not an allowable expense.

• If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

• If a person is covered by one plan that does not have negotiated charges and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on negotiated charges, the primary plan’s payment arrangement must be the allowable expense for all plans. However, if the health care
Provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated charge or payment amount that is different than the primary plan’s payment arrangement and if the health care provider or physician contract permits, the negotiated charge or payment must be the allowable expense used by the secondary plan to determine its benefits.

- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, preauthorization of admissions, and network provider and physician arrangements.

Allowed amount:
Allowed amount is the amount of a billed charge that a carrier determines to be covered for services by an out-of-network provider. The amount includes both the carrier’s payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

Closed panel plan:
Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

Custodial parent:
Custodial parent is the parent with the right to designate the primary residence of a child by court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Determining who pays
The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

A plan that does not contain a COB provision is always the primary plan.

<table>
<thead>
<tr>
<th>COB rule</th>
<th>Primary Plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or dependent</td>
<td>Plan covering you as an employee, policyholder, retired employee or subscriber (not as a dependent)</td>
<td>Plan covering you as a dependent</td>
</tr>
<tr>
<td>----------------------------</td>
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<tr>
<td></td>
<td>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</td>
<td>If you or your spouse have Medicare coverage, this may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Child – parents married or living together, whether or not they have ever been married</th>
<th>Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)</th>
<th>Plan of parent whose birthday is later in the year</th>
</tr>
</thead>
</table>
| Child – parents separated, divorced, or not living together, whether or not they have ever been married | • Plan of parent responsible for health coverage in court order  
• Birthday rule applies if both parents are responsible or have joint custody in court order  
• Custodial parent’s plan if there is no court order | • Plan of other parent  
• Birthday rule applies (later in the year)  
• Non-custodial parent’s plan |

| Child – covered by individuals who are not his or her parents (i.e. stepparent or grandparent) | Same rule as parent | Same rule as parent |

| Child of: Persons who are not his or her parents | The rules shown for parents will apply, as if the persons were parents of the child | The rules shown for parents will apply, as if the persons were parents of the child |

| Child of: Parents, who is also covered under a spouses plan | The plan has covered the person longer is primary  
If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse. | The plan has covered the person longer is primary  
If the coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse. |
<table>
<thead>
<tr>
<th>Active or inactive employee</th>
<th>Plan covering you as an active employee (or dependent of an active employee)</th>
<th>Plan covering you as a laid off or retired employee (or dependent of a former employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This rule does not apply if:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The “Non-dependent or Dependent” paragraph, above can determine the order of benefits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation</th>
<th>Plan covering you as an employee or retiree (or dependent of an employee or retiree)</th>
<th>COBRA or state continuation coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>This rule does not apply if:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The other plan does not have the rule, and as a result, the plans do not agree on the order of benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The “Non-dependent or Dependent” paragraph, above can determine the order of benefits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Longer or shorter length of coverage</th>
<th>Plan that has covered you longer</th>
<th>Plan that has covered you for a shorter period of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other rules do not apply</td>
<td>Plans share expenses equally</td>
<td>Plans share expenses equally</td>
</tr>
<tr>
<td></td>
<td>This plan will not pay more than it would have paid had it been the primary plan</td>
<td>This plan will not pay more than it would have paid had it been the primary plan</td>
</tr>
</tbody>
</table>

**Effect of prior plan coverage**

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

**Effect on the benefits of this plan**

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
  - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid
by the primary plan.
- May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
- Must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

**Compliance with federal and state laws concerning confidential information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

**Facility of payment**

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

**Right of recovery**

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

**Other health coverage updates – contact information**

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

**Recovery rights related to workers’ compensation**

If we pay more than we should have because workers’ compensation benefits paid for the same illness or injury, we may recover the excess from any of the following:

- Any person we paid or for whom we paid
- Any workers’ compensation plan that is responsible for payment
- Any fund designed to provide benefits for workers’ compensation claims

The recovery rights will be applied even if:

- The benefits are in dispute or are paid by means of settlement or compromise
- No decision has been made that the illness or injury was in the course of, or due to, your employment
- No agreement has been made by you, or the workers’ compensation plan, about the amount of benefits due to health care
- The health care benefits are excluded from the workers’ compensation settlement or compromise

By accepting benefits under this plan, you or your representatives agree to:

- Notify us of any workers’ compensation claim made
• Reimburse us as described

Our rights
We have the right to:
• Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
• Reimburse another health plan that paid a benefit we should have paid
• Recover any excess payment from a person or another health plan, if we paid more than we should have paid
The following content is added or replaced in the *Complaints, claim decisions and appeal procedures* section of your booklet-certificate:

**Complaints, claim decisions and appeal procedures**

**The difference between a complaint and an appeal**

**Complaint**

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You, someone who represents you, or your provider may file the complaint. You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

It is not a complaint if:

- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your provider call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations and Timeframes for deciding appeals of adverse determination* sections for more information.

Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know that we have received your complaint within 5 business days. Our letter will tell you about our complaint procedures and timeframes. If you call us to complain, we will send you a complaint form to complete and return.

If your complaint concerns an emergency, or denial of continued hospitalization or prescription drugs and intravenous infusions, we will do an expedited appeal review. See the *Appeal of adverse determinations and Timeframes for deciding appeals of adverse determinations* sections for more information.

**Adverse determinations**

An adverse determination is our determination that the health care services you have received, or may receive are:

- Experimental or investigational
- Not medically necessary

If we deny health care services because your provider does not request preauthorization or a concurrent claim extension, it is not an adverse determination.

If we make an adverse determination, we will tell you in writing. Our written decision will tell you:

- The main reason for denial
- The clinical reason for denial
- The source of the screening criteria used as a guideline to make the decision
- How to ask for an appeal of the denial, including your right to appeal to an independent review organization (IRO) and how to obtain an independent review
- How to obtain an immediate review by the IRO when the claim denial involves:
  - A life threatening condition
The provision of **prescription drugs** or intravenous infusions for which the patient is receiving health benefits under the policy

- Requests for **step therapy** exception

The chart below shows how much time we have to tell you about an adverse determination.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>When you need care to make sure you are stable following emergency treatment (post-stabilization)</th>
<th>While you are in the hospital</th>
<th>When not hospitalized at the time of the decision</th>
<th>Prescription drugs or other intravenous infusions that you are currently receiving</th>
<th>Retrospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial decision</td>
<td>No later than 1 hour after the request to the treating <a href="#">provider</a></td>
<td>Within 1 business day by phone or email to your <a href="#">provider</a> followed by written notice within 3 business days to you and your <a href="#">provider</a></td>
<td>Within 3 business days to you and your <a href="#">provider</a></td>
<td>No later than 30th day before on which the prescription drugs or intravenous infusions will be discontinued</td>
<td>Within 30 days after the date on which the claim is received</td>
</tr>
<tr>
<td>Extensions</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>15 days</td>
</tr>
<tr>
<td>Additional Information Request (us)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>30 days</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>45 days</td>
</tr>
</tbody>
</table>

**Important note:**
We will tell you about an adverse determination within the time appropriate to the circumstances relating to the delivery of the services and your condition. We will always tell no later than the times shown in the chart above.
Appeal
Your request to reconsider an adverse determination is an appeal of an adverse determination. It is also an appeal if you ask us to re-review a complaint because you are not happy with our initial response. The Appeal of a complaint and Appeal of adverse determinations sections below explain the appeal.

Claim decisions and appeal procedures
Your provider may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in Benefit payments and claims in the How your plan works section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision.

Appeal of a complaint
You can ask us to re-review your complaint. You can appeal by contacting us.

We will let you know that we have received your appeal within 5 business days. This notice will describe the appeals process and your rights. Part of this process is that we will assign a panel to review your appeal. You will have the opportunity to provide additional information for the panel to consider in the review your appeal. You or an authorized representative can attend the appeal hearing in person or by telephone.

The panel will include an equal number of:
- Non-employee members.
- Texas Health Aetna representatives who were not involved in making the initial decision.
- Providers (including specialists) who were not involved in making the decision. We will use a provider with experience in the area of care that is disputed.

We will send you the following information at least 5 days before the appeal panel hearing, unless you agree otherwise:
- A copy of any documentation to be presented by our staff
- The specialties of the physician or providers consulted during the review
- The name and affiliation of all Texas Health Aetna representatives on the appeal panel

You may respond to this information. The appeal panel will consider your response in their review.

The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include:
- The date we received the appeal request
- The panel’s understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the department of insurance at: Texas Department of Insurance P.O. Box 149104
If you ask, we will give you or your representative reasonable access to appeal information. This includes all documents, records and other information we used to decide the claim, or appeal. We will not charge you for the information.

**Appeal of an adverse determination**

**Urgent care or pre-service claim appeal**

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form.

**Any other claim appeal**

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse determination.

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by contacting us. You need to include:
- Your name
- The policyholder’s name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

We will let you know that we have received your appeal of the adverse determination within 5 business days. This notice will describe the appeals process and your rights. If you call us to appeal, we will send you an appeal form to complete and return.

The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse determination. You can respond to the information before we tell you what our final decision is.

**Expedited internal appeal**

You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a **hospital**. You can also ask for an expedited internal appeal if we deny a request for **step therapy** exception or a request for **prescription drugs** or intravenous infusions you are currently receiving.
**Important note:**
You can skip our standard and expedited internal appeal process and instead appeal to an independent review organization (IRO) in some situations. See the *Exhaustion of appeals process* section.

**Timeframes for deciding appeals of adverse determination**
The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision. We may tell you about our decision orally or in writing. If we tell you orally, we will send you a letter within 3 calendar days after the oral notice.

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>Our response time from receipt of appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care</strong> claim</td>
<td>As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received</td>
</tr>
<tr>
<td><strong>Emergency medical condition</strong></td>
<td>As soon as possible but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received</td>
</tr>
<tr>
<td>When you need care to make sure you are stable following emergency treatment (post-stabilization)</td>
<td>No later than 1 hour after the request</td>
</tr>
<tr>
<td>If you are hospitalized at the time of the adverse determination (may include concurrent care claim of hospital stays)</td>
<td>No later than 1 business day from the date all information to complete the review is received*</td>
</tr>
<tr>
<td>If you are receiving prescription drugs or intravenous infusions</td>
<td>As soon as possible but no later than 1 business day from the date all information to complete the review is received*</td>
</tr>
<tr>
<td>Pre-service claim requiring preauthorization</td>
<td>As soon as possible but no later than 15 calendar days*</td>
</tr>
<tr>
<td>Requests for step-therapy exception (non-emergency)</td>
<td>No later than 72 hours after we receive the request</td>
</tr>
<tr>
<td>Requests for step-therapy exception (emergency)</td>
<td>No later than 24 hours after we receive the request</td>
</tr>
<tr>
<td>Acquired brain injury</td>
<td>No later than 3 business after the request</td>
</tr>
<tr>
<td>Retrospective claim</td>
<td>As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*</td>
</tr>
<tr>
<td>Expedited internal appeal</td>
<td>As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received</td>
</tr>
</tbody>
</table>
*If your appeal is denied, your provider may ask us in writing to have a certain type of specialty provider review your case. The request must be made no later than 10 business days after the appeal was denied. A provider of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeal process
In most situations, you must complete an appeal with us before you can appeal through an external review process.

We encourage you to complete an appeal with us before you pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the independent review process at the same time.
- We did not follow all of the claim determination and appeal requirements of the Texas and the federal Department of Health and Human Services. But you will not be able to proceed directly to independent review if:
  - The rule violation was minor and not likely to influence a decision or harm you
  - The violation was for a good cause or beyond our control
  - The violation was part of an ongoing, good faith exchange between you and us
- You have a life-threatening condition. You can have your appeal reviewed through the independent review process.
- If you are receiving prescription drugs or intravenous infusion treatment and we deny them. You can have your appeal reviewed through the independent review process.
- Your request for a step therapy exception was denied. You can have your appeal reviewed through the independent review process.
Independent review

Independent review is a review done by people in an organization outside of Texas Health Aetna. This is called an independent review organization (IRO).

You have a right to independent review only if all the following conditions are met:

- You have received an adverse determination
- Our claim decision involved medical judgement
- We decided the service or supply is not medically necessary, not appropriate
- We decided the service or supply is experimental or investigational

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the request for independent review form.

You must submit the request for independent review form:

- To Texas Health Aetna
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

Texas Health Aetna will contact the IRO that will conduct the review of your claim. If your request is based on exigent circumstances your request will be sent as soon as possible. An “exigent circumstance means when you are:

- Experiencing a health condition that may seriously jeopardize your life, health or ability to regain maximum function
- Undergoing a current course of treatment using a non-formulary drug

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of independent review form with all the information you need to send in.

Sometimes you can get a faster independent review decision. Your provider must call us or send us a request for independent review form.

You may be able to get a faster independent review after an adverse determination if:

- Your provider tells us that a delay in your receiving health care services would:
  - Jeopardize your life, health or ability to regain maximum function
If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request or within 24 hour if your request is for an exigent circumstance.

**Utilization review**

**Prescription** drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

**Recordkeeping**

We will keep the records of all complaints and appeals for at least 10 years.

**Fees and expenses**

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

The following content is added or replaced in the *Eligibility, starting and stopping coverage* section of your booklet-certificate:

**Who can be a dependent on this plan**

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including any children placed with you for adoption*
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody
    - Grandchild who is your dependent for federal tax purposes at the time application for coverage of the grandchild is made

*Your adopted child may be enrolled as shown in the *When you can join the plan* section, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final
Adding new dependents
You can add new dependents during the year. These include any dependents described in the Who can be a dependent on this plan section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- **Birth:**
  - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- **Adoption or placement for adoption:**
  - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after you become a party in a suit for adoption or the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become a party in a suit for adoption or the adoption is complete.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- **Marriage**
- **Legal guardianship**
- **Court or administrative order**

We must receive a completed enrollment form not more than 31 days after the event date.

Stopping coverage
Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn’t always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the Special coverage options after your coverage ends section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end
Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required premium contributions, if any apply
- We end your coverage for one of the reasons shown in this section
- You start coverage under another medical plan offered by your employer
When dependent coverage ends
Dependent coverage will end if:
• A dependent is no longer eligible for coverage.
• You stop making premium contributions, if any apply.
• Your coverage ends for any of the reasons listed above except:
  – Exhaustion of your overall maximum benefit.
  – You enroll under a group Medicare plan we offer.

Your employer will notify Aetna of the date your coverage ends. You and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:
• Your employer notifies you at least 30 days before coverage ends
• You and your dependents are covered under COBRA or state continuation
• You and your dependents are enrolled in another health plan that starts before the end of the month after we receive the notice

What happens to your dependents if you die?
Coverage for dependents may continue for some time after your death. See the Special coverage options after your coverage ends section for more information.

Why would we end your coverage?
We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the General provisions – other things you should know section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

We will not end your coverage based on your health care status or needs, we also will not end your coverage because you used your rights under the Complaints, claim decisions, and appeal procedures section.

Continuation of coverage – State of Texas

Continuation privilege for certain dependents
There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

<table>
<thead>
<tr>
<th>Qualifying event causing loss of coverage:</th>
<th>Covered persons eligible for continued coverage:</th>
<th>Length of continued coverage (starts from the day you lose current coverage):</th>
</tr>
</thead>
</table>
| • Death of employee
  • Retirement of employee
  • Retirement of employee | • Dependent who has been covered under the plan for at least one year
  • An infant under one year of age | 3 years |

When do I receive state continuation information?
The chart below lists who must give notice, the type of notice required, and the time period to give the notice.
<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>You or your covered spouse</td>
<td>Send written notice to your employer</td>
<td>Within 15 days of the qualifying event</td>
</tr>
<tr>
<td>Your employer</td>
<td>Will provide you with an enrollment form to continue coverage</td>
<td>No later than 15 days after they receive notification</td>
</tr>
<tr>
<td>You or your covered spouse</td>
<td>Complete the enrollment form to continue coverage</td>
<td>Within 60 days of the qualifying event</td>
</tr>
</tbody>
</table>

You must send the completed enrollment form from within 60 day of the qualifying event. If you don’t, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

**Group continuation privilege**
You may continue coverage if your coverage ends for any reason except:
- Involuntary termination for cause
- Discontinuance of the group agreement
To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:
- Your coverage ends or
- You are given notice by the contract holder

Your first premium payment must be made within 45 days after the date of the coverage election. After that, premium payments are due no later than the end of the grace period after the premium due date.

You can continue coverage until the earliest of:
- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

**Continuation of coverage – State of Texas**

**Continuation privilege for certain dependents**
There are events that may cause your dependents to lose coverage. For some events, certain dependents are eligible to continue their coverage for a time. Here are the events, eligible dependents and time periods:

<table>
<thead>
<tr>
<th>Qualifying event causing loss of coverage:</th>
<th>Covered persons eligible for continued coverage:</th>
<th>Length of continued coverage (starts from the day you lose current coverage):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of employee</td>
<td>Dependent who has been covered under the plan for at least one year</td>
<td>3 years</td>
</tr>
<tr>
<td>Retirement of employee</td>
<td>An infant under one year of age</td>
<td></td>
</tr>
</tbody>
</table>

AL COCAmend-ET 01 110 TX
When do I receive state continuation information?
The chart below lists who must give notice, the type of notice required, and the time period to give the notice.

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>You or your covered spouse</td>
<td>Send written notice to your employer</td>
<td>Within 15 days of the qualifying event</td>
</tr>
<tr>
<td>Your employer</td>
<td>Will provide you with an enrollment form to continue coverage</td>
<td>No later than 15 days after they receive notification</td>
</tr>
<tr>
<td>You or your covered spouse</td>
<td>Complete the enrollment form to continue coverage</td>
<td>Within 60 days of the qualifying event</td>
</tr>
</tbody>
</table>

You must send the completed enrollment form from within 60 day of the qualifying event. If you don’t, you will lose the right to continue coverage. We will cover your dependent during this period as long as the premiums and administrative charges are paid.

**Group continuation privilege**

You may continue coverage if your coverage ends for any reason except:
- Involuntary termination for cause
- Discontinuance of the group agreement

To continue coverage, you must be covered for at least 3 months in a row right before your coverage ends.

You must give your employer written election of continuation no more than 60 days following the later of the date:
- Your coverage ends or
- You are given notice by the contract holder

Your first premium payment must be made within 45 days after the date of the coverage election. After that, premium payments are due no later than the end of the grace period after the premium due date.

You can continue coverage until the earliest of:
- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date election is made, if you are not eligible for COBRA
- The date you fail to pay premiums
- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan
The following content is added or replaced in the General Provisions section of your booklet-certificate:

**Administrative provisions**

**How you and we will interpret this certificate**
We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws.

**How we administer this plan**
We apply policies and procedures we’ve developed to administer this plan.

**Who’s responsible to you**
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even network providers are not our employees or agents.

**Coverage and services**

**Your coverage can change**
Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive preauthorization, prescription quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or provider, can do this. Any modifications made will be no less favorable than the current plan requirements.

**Legal action**
You are encouraged to complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the Complaints, claim decisions, and, appeal procedures section. You cannot take any action until 60 days after we receive written submission of a claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

**Notice of claim**
You must give us written notice of claim within 20 days (or as soon as reasonably possible) after you have incurred expenses for covered services. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the Proof of loss section below.

**Physical examination and evaluations**
At our expense, we have the right to have a physician of our choice examine you. This will be done at reasonable times while certification or a claim for benefits is pending or under review.

**Proof of loss**
You must submit written proof of loss you within 90 days after your loss occurs. If you couldn’t reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).
Time of payment of claims
We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the Proof of loss section above.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:
- Names of physicians and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years after the effective date of this certificate.

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:
- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the Benefit payments and claims, Filing a claim section for information about rescission.

You have special rights if we rescind your coverage:
- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an Aetna appeal
- You have the right to a third party review conducted by an independent IRO

We won’t rescind your coverage due to an intentional deception if the deception happened more than 2 years after the effective date of this certificate.

In the absence of fraud, any statement made on your application for coverage is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

Premium contribution
Your plan requires that the policyholder make premium contribution payments. We will not pay for benefits if premium contributions are not made by the end of the grace period. Any decision to not pay benefits can be appealed.
When you are injured by a third party

If a third party caused you to need care—say, a careless driver who injured you in a car crash—you may have a right to get money for your injuries. If you have a legal right to get money from a third party for causing your injuries, we are entitled to that money, up to the amount we pay for your care.

When you have a legal right to get money from one or more third parties for causing your injuries and you pursue that legal right, you are:

- Agreeing to repay us from money you receive from those third parties because of your injury.
- Giving us the right to seek money in your name, from those third parties because of your injuries.
- Agreeing to cooperate with us so we can get paid back in full, up to the applicable amount noted below. For example, you’ll tell us within 30 days of when you seek money from those third parties for your injury or illness. You’ll hold any money you receive until we are paid in full. And you’ll give us the right to our portion of the money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money. Notify us by contacting us.

We will only seek money from your own uninsured/underinsured motorist or medical payments coverage (if any) if you or your immediate family member did not pay premiums for the coverage.

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, less attorney’s fees and costs for the recovery, or
- The total amount paid by us, less attorney’s fees and costs for the recovery

How will Attorney’s fees be determined?

If we do not use an attorney:

- We (and any other payors) will pay your attorney a fee agreed to between us (and other payors) and your attorney plus a pro rata share of the recovery expenses
- If no agreement exists, then the court will award your attorney a reasonable fee payable for our (and any other payors) share of the recovery not to exceed 1/3 of the recovery

If we use an attorney:

- The court will award attorney’s fees to our attorney and your attorney based on the benefit accruing as a result of each attorney’s service. The total attorney’s fees may not exceed 1/3 of our (and any other payors) recovery.

Payor means a plan issuer that:

- Has a contractual right of subrogation, and
- Pays benefits to you or on your behalf as a result of personal injuries caused by someone else’s tortious conduct

A payor includes, but is not limited to, an issuer of:

- A health benefit that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness
- A disability benefit plan
- An employee welfare benefit plan
Payment to a conservator, other than you
Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:
- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for covered services that you paid

Reimbursement to Texas Department of Human Services
We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:
- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession or access to the child through a court order; or
  - Are not entitled to possession of our access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Texas Medical ET
Issue Date: January 23, 2023
Aetna Life Insurance Company

Extraterritorial booklet-certificate amendment

Policyholder: Pace University

Group policy number: GP-0181579

Amendment effective date: January 1, 2023

This amendment is part of your booklet-certificate. It is effective on the date shown above and it replaces any other medical extraterritorial booklet-certificate amendment you may have received before.

Important note: The following apply only if you live in Washington. The benefits below will apply instead of those in your booklet-certificate.

Domestic Partners
If your plan includes coverage for dependents, you can also enroll the following family members on your plan.

- Your domestic partner and their dependent children

Adding new dependents
If your plan includes coverage for dependents, you can add the following new dependents any time during the year:

- A newborn child - Your newborn child is covered on your plan for the first 31 days after birth
  - When additional premiums are required, you must enroll the child within 60 days of birth to keep the newborn covered
  - If you miss this deadline, your newborn will not have benefits after the first 31 days
- An adopted child - You may put an adopted child on your plan on the date the child is placed for adoption
  - “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child
  - When additional premiums are required, you must enroll the child within 60 days of placement
  - Your adopted child’s coverage will start from the date of placement
  - If you miss this deadline, your adopted child will not have benefits
- A stepchild - You may put a child of your spouse or domestic partner on your plan
  - You must enroll the child within 60 days of the date of your marriage or domestic partnership with your stepchild’s parent
  - The benefits for your stepchild will begin the first day of the month following the date we receive your completed enrollment information

Mammograms
Eligible health services include the following routine cancer screenings:

- Mammograms, including 3-D mammograms (tomosynthesis)
Neurodevelopmental therapy

Eligible health services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an illness or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an illness or because of a condition you had when you were born

Home health care

Eligible health services include home health care services and home dialysis services provided by a home health care agency in the home, but only when all of the following criteria are met:

- You are homebound
- Your health professional orders them
- The services take the place of a stay in a hospital or a skilled nursing facility, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services, palliative care services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse (R.N.)
- Medical social services are provided by or supervised by a physician, other health professional or social worker

Short-term physical, speech and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home.

Home health care services do not include custodial care.

Exclusions

Your plan does not cover the following under this section:

- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care

Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program.

The types of hospice care services that are eligible for coverage include:

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Bereavement counseling
- Respite care
- Palliative care
Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:

- A physician or other health professional for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling
  - Dietary counseling
  - Palliative care

Exclusions
Your plan does not cover the following under this section:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Abortion
Eligible health services include services and supplies for an abortion. This is the voluntary termination of pregnancy performed by a health professional.

Acupuncture
Eligible health services include acupuncture. The service performed must be within the scope of an East Asian Medicine Practitioner’s license, as regulated by Washington state law.

Mental Health Parity
In no event will the cost share for mental health services be any more restrictive than that for any other physician services covered under the plan.

Nutritional supplements
Eligible health services include amino acid modified preparations, dietary specialized formulas and low protein modified food products for the treatment of inherited metabolic diseases including phenylketonuria and eosinophilic gastrointestinal disorder.

For purposes of this benefit, “low protein modified food product” means foods that are specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a health professional for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Exclusions
Your plan does not cover the following under this section:

Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered above
Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of jaw joint disorder by a provider which includes:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD)

The following are not covered under this benefit:

- Non-surgical treatment of jaw joint disorder

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

How can you extend coverage during a strike, lockout or other labor dispute?

You have a right to extend coverage for you and your dependents even if you are absent from work because of a strike, lockout or other labor dispute if:

- You were covered on the date you stopped working, and
- You paid your premium when due

You can continue your coverage for up to 6 months if you pay your premiums to your employer. Your employer will send your payment to Aetna. Call the number on your ID card to get the process started. Your coverage will continue until:

- You go to work full-time for another employer
- You do not make the required premium payments
- The labor dispute ends, or
- The 6 months continuation period ends

Your premium payment will be the same rate you were paying on the date you stopped working. But, if the premium amount your employer has to pay changes during the time you are extending your coverage, your premiums will also change.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section when we talk about a “plan” through which you may have other coverage for health care expenses, we mean:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other governmental benefits
• Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works
• When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
• When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
• We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

<table>
<thead>
<tr>
<th>If you are covered as a:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or dependent</td>
<td>The plan covering you as a non-dependent</td>
<td>The plan covering you as a dependent</td>
</tr>
<tr>
<td>Exception to the rule above when you are eligible for Medicare</td>
<td>If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Online: Log on to your Aetna secure member website at <a href="http://www.aetna.com">www.aetna.com</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• By phone: Call the number on your ID card</td>
<td></td>
</tr>
</tbody>
</table>

COB rules for dependent children

Child of:
- Parents who are married or living together
  - The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the calendar year.
  - *Same birthdays-the plan that has covered a parent longer is primary.

Child of:
- Parents separated or divorced or not living together
  - The plan of the parent whom the court said is responsible for health coverage.
  - But if that parent has no coverage then their spouse’s plan is primary.
  - The plan of the other parent.
  - But if that parent has no coverage, then their spouse’s plan is primary.

Child of:
- Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody
  - Primary and secondary coverage is based on the birthday rule.

Child of:
- Parents separated or divorced or not living
  - The order of benefit payments is:
    - The plan of the custodial parent pays first
    - The plan of the spouse of the custodial parent (if any) pays
<table>
<thead>
<tr>
<th>together and there is no court-order</th>
<th>second</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The plan of the noncustodial parents pays next</td>
<td></td>
</tr>
<tr>
<td>• The plan of the spouse of the noncustodial parent (if any) pays last</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)</th>
<th>Treat the person the same as a parent when making the order of benefits determination. See Child of content above.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Active or inactive employee</th>
<th>The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COBRA or state continuation</th>
<th>The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Longer or shorter length of coverage</th>
<th>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other rules do not apply</td>
<td>If none of the above rules apply, the plans share expenses equally.</td>
</tr>
</tbody>
</table>

### How are benefits paid?

<table>
<thead>
<tr>
<th>Primary plan</th>
<th>The primary plan pays your claims as if there is no other health plan involved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary plan</td>
<td>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.</td>
</tr>
<tr>
<td></td>
<td>The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit reserve</th>
<th>The benefit reserve:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each family member has a separate benefit reserve for each calendar year</td>
<td>• Is made up of the amount that the secondary plan saved due to COB</td>
</tr>
<tr>
<td></td>
<td>• Is used to cover any unpaid allowable expenses</td>
</tr>
<tr>
<td></td>
<td>• Balance is erased at the end of each year</td>
</tr>
</tbody>
</table>

### How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.
You are eligible for Medicare when you are covered under it by reason of:

- Age
- Disability
- End stage renal disease

When you are enrolled for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid.

**Who pays first?**

<table>
<thead>
<tr>
<th>If you are eligible due to age and have group health plan coverage based on your or your spouse’s current employment and:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The employer has 20 or more employees</td>
<td>Your plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>You are retired</td>
<td>Medicare</td>
<td>Your plan</td>
</tr>
</tbody>
</table>

**If you have Medicare because of:**

<table>
<thead>
<tr>
<th>End stage renal disease (ESRD)</th>
<th>Your plan will pay first for the first 30 months.</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare will pay first after this 30 month period.</td>
<td>Your plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A disability other than ESRD and the policyholder has more than 100 employees</th>
<th>Your plan</th>
<th>Medicare</th>
</tr>
</thead>
</table>

Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.

This plan is secondary to Medicare in all other circumstances.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

**Other health coverage updates – contact information**

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Aetna secure member website
- **By phone:** Call the number on your ID card

**Right to receive and release needed information**

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.
**Right to pay another carrier**
Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

**Right of recovery**
If we pay more than we should have under the COB rules, we may recover the excess from:
- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.

**Important note:** If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your providers and plans any changes in your coverage.

**When you disagree - claim decisions and appeals procedures**
In the previous section, we explained how you and we share responsibility for paying for your eligible health services.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

**Claim procedures**
For claims involving out-of-network providers:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submit a claim</strong></td>
<td>• You should notify and request a claim form from us</td>
<td>• You must send us notice and proof as soon as reasonably possible &lt;br&gt; • If you are unable to complete a claim form, you may send us: &lt;br&gt; - A description of services &lt;br&gt; - Bill of charges &lt;br&gt; - Any medical documentation you received from your provider</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s)</td>
<td></td>
</tr>
<tr>
<td><strong>Proof of loss (claim)</strong></td>
<td>• A completed claim form and any additional information required by us</td>
<td>• You must send us notice and proof as soon as reasonably possible &lt;br&gt; • You must send us notice and proof as soon as reasonably possible</td>
</tr>
<tr>
<td><strong>Benefit payment</strong></td>
<td>• Written proof must be</td>
<td>• Benefits will be paid as</td>
</tr>
</tbody>
</table>
Types of claims and communicating our claim decisions

You or your provider is required to send us a claim in writing. If you or your dependent goes to a network provider, the network provider will file the claims. When you go to an out-of-network provider, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the provider or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim
An urgent claim is one for which the health professional treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim
A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension
A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization.

During this continuation period, you are still responsible for your share of the costs, such as copayments/coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.
We may need to tell your **health professional** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>Within 48 hours or Within 1 business day for an emergency request</td>
<td>5 calendar days</td>
<td>30 calendar days</td>
<td>No later than 24 hours for urgent request* or 5 calendar days for non-urgent request</td>
</tr>
<tr>
<td>Request for Extension</td>
<td>Not applicable</td>
<td>Within 5 calendar days</td>
<td>15 calendar days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>24 hours</td>
<td>5 calendar days</td>
<td>30 calendar days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to receipt of additional information request (you)</td>
<td>48 hours</td>
<td>30 calendar days</td>
<td>45 calendar days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*We have to receive the request at least 24 hours before the previously approved health care services end.

**Adverse benefit determinations**

We pay many claims at the full rate **negotiated charge** if you go to a **network provider** and the **recognized charge** if you go to an **out-of-network provider**, except for your share of the costs.

But sometimes we may pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:
- Deny
- Change
- Reduce, or
- Terminate your
- Health care services or benefits
- Authorization relating to such services or benefits, or
- Coverage or payment for the health care services or benefits

Such actions are called “adverse benefit determinations.” Other actions that are also called “adverse benefit determinations” include:
- We do not authorize a **stay** in a **hospital** or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely
Reasons for adverse benefit determinations may be:

- The results of utilization review activities
- The health care services are experimental or investigational
- The health care services are not medically necessary

If we make an adverse benefit determination, we will tell you in writing.

The difference between a grievance and an appeal

A grievance
You may not be happy about a provider or an operational issue, and you may want to complain. You can call the number on your ID card, or write us. Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the grievance. We will let you know if we need more information to make a decision.

An appeal
You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the number on your ID card.

Appeals of adverse benefit determinations
You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by calling the number on your ID card. You need to include:

- Your name
- The policyholder’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling the number on your ID card. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

Urgent care or pre-service claim appeals
If your claim is an urgent claim or a pre-service claim, your provider may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals
The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to
tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>24 hours, but no longer than 72 hours</td>
<td>14 days, or 20 days for an experimental or investigational treatment. We will let you know within 72 hours that we have received your appeal</td>
<td></td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extension to respond (us)</td>
<td>None</td>
<td>16 additional days, if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Exhaustion of appeals process**

In most situations you must complete the one level of appeal with us before you can pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete our appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
  - Minor and not likely to influence a decision or harm you
  - For a good cause or beyond our control
  - Part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner to request an investigation of a grievance or appeal.

**External review**

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external review if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To Aetna
- Within 180 calendar days of the date you received the decision from us
And you must include a copy of the notice from us and all other important information that supports your request.

You will pay for any information that you send and want reviewed by the ERO. We will pay for information we send to the ERO plus the cost of the review.

Aetna will contact the ERO that will conduct the review of your claim.

The ERO will:
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an ERO decision?
We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your provider must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping
We will keep the records of all grievances and appeals for at least 10 years.
Fees and expenses
We do not pay any fees or expenses incurred by you when you submit a grievance or appeal.

Out-of-network benefits disclosure
Your health plan’s out-of-network benefits
Not all health coverage plans provide out-of-network benefits. Please refer to your schedule of benefits for a description of your health plan’s out-of-network benefits.

Notice of consumer rights
Washington State has developed a notice of consumer rights. You can find this in your certificate of coverage.

Out-of-network costs
You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on whether the provider, a doctor or hospital, is “in network” or “out of network.” We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

“In network” means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

“Out of network” means we do not have a contract for discounted rates with that doctor. We don’t know exactly what an out-of-network doctor will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance, copayments, and deductible that applies. Your network doctor will handle any precertification your plan requires.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan “recognizes” or “allows.” Your doctor may bill you for the dollar amount that the plan doesn’t recognize. You’ll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the “recognized charge” counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

How to use the transparency tool
Aetna provides online tools to help you determine the cost of health care services and your potential share of those expenses. After logging in to our member website, you can search for procedures and providers to see estimated costs.

Search our network for doctors, hospitals and other health care providers
Use our online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code or enter a specific doctor’s name in the search field.

Visit Aetna.com and log in. From your secure member website home page, select “Find Care” from the menu bar and start your search.
Our online search tool is more than just a list of doctors’ names and addresses. It also includes information about:
• Where the doctor went to medical school
• Board certification status
Obtain an estimated range of the out-of-pocket costs for an out-of-network benefit

Contact member services at the number on your ID card for help estimating your out-of-pocket cost for an out-of-network benefit. Out-of-network providers do not have a contracted rate with Aetna. We don’t know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor’s bill. However, your out-of-pocket costs may be much higher compared to the costs of using a network provider. Your out-of-pocket costs for an out-of-network benefit, if included in your plan, consists of your out-of-network deductible plus your plan coinsurance. To estimate your coinsurance amount, subtract the remaining plan deductible from the provider’s billed charge. Then multiply the balance by your coinsurance percentage.

Policies and plans are insured and/or administered by Aetna Life Insurance Company or its affiliates (Aetna).

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Refer to Aetna.com for more information about Aetna® plans.

Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted, or if the doctor or facility performs a different service at the time of your visit.

This amendment makes no other changes to the group policy, booklet-certificate or schedule of benefits.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Amendment: Washington Medical ET
Issue Date: January 23, 2023